Wisconsin State Legislature

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Joint Committee on Finance
100TH ANNIVERSARY 1911 - 2011

MEMORANDUM

To: Members
Joint Committee on Finance

From: Senator Alberta Darling
Representative Robin Vos

Date: October 31, 2011

Re: 14-Day Passive Review Approval – DHS

Pursuant to s. 49.45(2m)(d), Stats., attached is a is 14-day passive review request from the Department of Health Services, received on October 31, 2011.

Please review the material and notify **Senator Darling** or **Representative Vos** no later than **Thursday, November 17, 2011** if you have any concerns about the request or if you would like the Committee to meet formally to consider it.

Also, please contact us if you need further information.

Attachment (add an "s", if more than one attachment)

AB:RV:jm

State of Wisconsin
Department of Health Services

Scott Walker, Governor
Dennis G. Smith, Secretary

October 31, 2011

The Honorable Alberta Darling, Senate Co-Chair
Joint Committee on Finance
Room 317 East, State Capitol
Madison, WI 53702

The Honorable Robin Vos, Assembly Co-Chair
Joint Committee on Finance
Room 309 East, State Capitol
Madison, WI 53702

Dear Senator Darling and Representative Vos:

On September 30th, I provided you an update on the overall Medicaid budget and the efficiency measures the Department is pursuing to achieve the savings goals established in the 2011-13 biennial budget. I indicated that, for those measures that conflict with current statutes, the Department would formally submit them to the Committee under s. 49.45(2m)(d) at a later date after obtaining public input.

As I indicated previously, the Department's efficiency measures aim to achieve sustainability for the Medicaid program now and into the future, by aligning coverage with what working families receive in the private market, by improving the effectiveness of service delivery to enrollees with complex care needs, and by reforming payment methods to providers.

Since my previous letter, we have refined our proposals based on input received through two public hearings and comments through the Department's website. We have also reached agreement with the Legislative Fiscal Bureau regarding which items require submittal to the Committee. Attached is a list of those items along with the Medicaid waiver and state plan amendment documents the Department will submit to the federal Centers for Medicare and Medicaid Services once the Committee has completed its review. The items I am submitting to you today represent a portion of the $335 million GPR Medicaid savings plan the Department is pursuing to keep the program in balance in the current biennium. The Department has current statutory authority to implement the remaining items in the plan released on September 30th. These include implementing the Family Care enrollment cap, HMO and hospital pay for performance measures, and audit enhancements, aligning Medicaid reimbursement with Medicare, and maximizing drug rebate revenues, among other measures.

Thank you for your consideration of this information. If you have any questions, please feel free to contact me.

Sincerely,

Dennis G. Smith
Secretary

cc: Members of the Joint Committee on Finance
Legislative Fiscal Bureau

Medicaid Efficiency Measures
Items for Submission to the Joint Committee on Finance under s. 49.45(2m)(d)

Item	*Section*
PPACA Maintenance of Effort Waiver	
Eligibility Standardization	49.471(8)(b)
Failure to Pay Reforms	49.471(10)(b)
Income Determination Update	49.471(4),(5),(6),(7),(8),(9),(10)
Retroactive BadgerCare Plus Eligibility	49.471(6)(a)
Premium Reforms	49.471(10)(b)
Presumptive Eligibility	49.471(5)
Streamlined Eligibility Termination Process	DHS 103.09(1)
Young Adults Eligibility Restrictions	49.471(8)(b)
Standards for State Residence	DHS 102.03(1)
Transitional Medicaid Discontinuation	49.471(4)(a)(7)
Benchmark Plans	
Family Medicaid Benchmark Plan	49.471(4)&(11)
Birth to 3 Program Benchmark Plan	49.46(2)(b)(intro)&17.
Conversion of 1915(i) to 1937 Benchmark Alternative	49.46(2)(b)6.Lo.
Medical Homes	
Children in Foster Care Medical Home	49.46(2)(a)&(b)(intro)
Healthy Birth Outcome Medical Home for Pregnant Women	49.46(2)(a)&(b)(intro)
Medical Home for People With a Mental Health Diagnosis	49.46(2)(a)&(b)(intro)
Medical Home for People Leaving the Criminal Justice System	49.46(2)(a)&(b)(intro)
Individuals with Chronic Conditions Medical Home	49.46(2)(a)&(b)(intro)

State of Wisconsin
Medicaid 2014 Waiver

Understanding the Impact of New Federal Policies on the Affordability of Health Insurance, Medicaid Eligibility Simplification, Adoption of Rules on Income, and Medicaid Interaction with Real-time Web-Based Applications

1115 Demonstration Project Application

November x, 2011

Wisconsin Department of Health Services

Table of Contents

Medicaid 2014 Demonstration Project

An initiative to test the policy impacts of the federal law on Medicaid to go into effect in 2014, including crowd-out policies, cost-sharing requirements, income determination methods, adverse selection provisions, the relevance of Transitional Medicaid and the impact of real-time eligibility on verification requirements and retroactive and presumptive determinations.

Part I: Statement of Purpose

Introduction

The Patient Protection and Affordable Care Act (PPACA) will fundamentally change policies that govern state Medicaid programs. Wisconsin is submitting this federal 1115 waiver to pilot several policies that will prepare our BadgerCare Plus programs to better align with the pending changes in federal law.

Wisconsin is uniquely positioned to undertake this pilot demonstration. Our existing BadgerCare Plus program includes parents and childless adults up to 200% of the federal poverty level (FPL) as well as children and pregnant women up to 300% FPL.

Thus, BadgerCare Plus currently includes families and individuals whose incomes cross the federal threshold for Medicaid and subsidized insurance authorized by PPACA beginning in 2014. In that year, adults with incomes greater than 133% FPL (or 138% without income disregards) will be required to purchase private health insurance, while adults with incomes below 133% will be eligible for Medicaid.

Wisconsin, therefore, through this Medicaid 2014 waiver, is positioned to demonstrate the impact of pending PPACA policies on potential Medicaid and subsidy participants and to model the way policy decisions will impact the interaction between these two coverage sources.

It is our belief that CMS approval of Wisconsin's Medicaid 2014 Waiver is critical not only to our own success in building a bridge to 2014 but to the national policy dialogue surrounding implementation of these untested federal policies.

The following summary of Medicaid 2014 Waiver provisions describes the key role each one plays in testing significant policy parameters of PPACA's impact on Medicaid and the resulting coverage outcomes of lower-income Americans.

Part II: Current Environment

Wisconsin has been successful achieving widespread health care access without a federal mandate. In 1999, the state implemented BadgerCare to provide a health care safety net for low-income families transitioning from welfare to work.

BadgerCare Plus expanded coverage to families at higher income levels. Beginning in 2008, the following groups were eligible for coverage:

1) All uninsured children (birth through age 18) regardless of income
2) Pregnant women with incomes up to 300% of the FPL
3) Parents and caretaker relatives with incomes up to 200% of the FPL
4) Caretaker relatives with incomes up to 200% of the FPL
5) Parents with children in foster care with incomes up to 200% of the FPL
6) Youth (ages 18 through 20) aging out of Wisconsin's foster care system
7) Farm families and other self-employed parents with dependent children with incomes up to 200% of the FPL, contingent upon depreciation calculations.

Wisconsin also implemented the Core Plan for childless adults with incomes less than 200% FPL through an 1115 waiver in 2009.

Wisconsin has also maintained for many years one of the leading eligibility information systems in the country. Our "Access" web portal (access.wi.gov) has been duplicated by many other states because it provides the public with an easy, online method for submitting a Medicaid application.

All of these factors make Wisconsin the ideal setting for implementation of a waiver aimed at understanding the impact of new federal policies on the affordability of health insurance, Medicaid eligibility simplification, adoption of rules on income, and Medicaid interaction with real-time web-based applications

III. Waiver Description

The following summary of Medicaid 2014 Waiver provisions describes the key role each one plays in testing significant policy parameters of PPACA's impact on Medicaid and the resulting coverage outcomes of lower-income Americans.

Crowd Out

The Patient Protection and Affordable Care Act (PPACA) disqualifies lower-income families above the poverty line from eligibility for government-subsidized health coverage if they have access to an employer-sponsored plan that does not require premiums in excess of 9.5% of household income.

The Medicaid 2014 Waiver will test this affordability threshold by applying a similar standard to BadgerCare Plus members in a similar income range. The waiver evaluation will look at how individuals not eligible for BadgerCare Plus based on this crowd-out provision subsequently interact with the private health care market. Do they follow-through with maintaining coverage at the expected levels of cost-sharing?

PPACA also disqualifies lower-income young adults above the poverty line from eligibility for government-subsidized health coverage if they have access to coverage under a parent's employer-sponsored insurance plan.

The Medicaid 2014 Waiver will align BadgerCare Plus crowd-out provisions with this policy to test whether or not young adults subsequently enroll in their parents plan and maintain access to health coverage.

Cost Sharing

PPACA requires families and individuals to purchase insurance that will require premium and copayment contributions. According to a recent study released by the Urban Institute, the estimated average annual premium cost for families with incomes between 138% and 200% FPL is $1,559 in 2014, with additional estimated out-of-pocket expenses of $457.

Wisconsin's Medicaid 2014 waiver will move toward aligning BadgerCare Plus cost-sharing provisions with those authorized by PPACA. This will demonstrate the impact of cost-sharing provisions on lower-income families above the poverty line. Will participants pay? Will the cost-sharing requirements slow the growth of health care spending? The demonstration will consider policy choices related to the alignment of benefits and the equity of cost-share provisions for Medicaid, the Basic Health Plan and subsidized insurance.

Transitional Medical Assistance (TMA)

TMA itself is not authorized under PPACA, but has existed for many years to support the transition from welfare to work. TMA allows individuals to maintain their Medicaid coverage for 12 additional months once their income changes from an amount that would have qualified them for benefits under the former Aid to Families with Dependent Children (AFDC) cash assistance program to an amount above that income threshold.

In Wisconsin, the AFDC income threshold is 100% of the federal poverty level (FPL). TMA policy in Wisconsin has never been adjusted to reconcile to expanded eligibility criteria for Medicaid. Beginning in 2008, parents with incomes up to 200% FPL

became eligible for BadgerCare Plus. This meant that, even without TMA, a person below the poverty line could have at least twice as much earned income without losing Medicaid coverage.

The future of TMA in the context of PPACA implementation is uncertain since the program's authorization expires before 2014. Continuation of TMA will introduce inequities because it will result in families with the same income experiencing different eligibility outcomes.

Therefore, the Wisconsin 2014 Waiver proposes to demonstrate how ending TMA interacts with an environment where low-cost coverage remains available to individuals.

Under the waiver, those who would otherwise be exempt from cost-sharing under TMA will be expected to make modest premium and other cost-sharing contributions to maintain their Medicaid coverage. This simulates how a Medicaid to subsidized insurance transition would work for these same individuals if TMA is ended nationally.

This demonstration would have national significance for policy decisions related to the future of the Transitional Medical Assistance program.

Restrictive Re-Enrollment

Even with the tax penalties envisioned under PPACA for failure to comply with the insurance mandate, consumers may have financial incentives to selectively purchase coverage for specific months in which they anticipate high utilization

Therefore, policies to prevent such adverse selection will be critical in 2014 and beyond. The Wisconsin 2014 waiver will test the impact of applying restrictive re-enrollment as a measure of protection against adverse selection.

The waiver will evaluate the impact of the policy on premium payment compliance and the overall PMPM for BadgerCare Plus members in populations subject to this policy.

Again, the outcome of the demonstration will provide insights of national significance related to policies aimed at assuring the financial solvency of long-term health care.

Real-Time Eligibility

PPACA envisions that a real-time eligibility process for Medicaid and subsidized insurance is in place by January 1, 2014.

A key component of Wisconsin's Medicaid 2014 waiver will be to implement real-time eligibility during Demonstration Year 1. This implementation raises policy questions about a variety of Medicaid eligibility provisions designed to address application processing time and the definition of Medicaid eligibility begin and end dates.

The Medicaid 2014 waiver will test the impact on eligibility by replacing retroactive and presumptive eligibility policies with a real-time, online application system designed to facilitate immediate access to Wisconsin's health care safety net.

The real-time system will redefine and modernize the logic of outdated methods used to calculate a recipient's eligibility begin date and end date. Wisconsin's Medicaid 2014 Waiver will demonstrate the potential efficiency of operating a real-time eligibility system and the potential savings states can achieve by avoiding the unnecessary costs associated with arbitrary backdating and end-dating.

To assure program integrity and the effective use of public tax dollars, the accuracy of online eligibility determinations must be supported by a strong back end quality control process. In our Medicaid 2014 Waiver, Wisconsin proposes to demonstrate the interaction of real-time eligibility with a back end verification process by strengthening our state residency verification requirements.

Redefining Household Income

PPACA will fundamentally change the way income is measured for Medicaid eligibility purposes in 2014. The new method required for use is based on Internal Revenue Service (IRS) "Modified Adjusted Gross Income" rules.

In Wisconsin, it is unclear whether MAGI rules will accurately capture the total sum of household resources available to applicants and recipients of the publicly-funded Medicaid program.

Therefore, Wisconsin requests authority through our proposed Medicaid 2014 Waiver to pilot an alternative methodology that considers the resources of all adults living in the household of the person who is filing the application.

In doing this, Wisconsin will gather data significant to assessing whether MAGI comprehensively captures household resources. This demonstration will also help Wisconsin assess the expected total Medicaid enrollment in 2014 based on a clearer picture of how the income methodology affects household eligibility.

IV. Demonstration/Hypothesis

The Medicaid 2014 waiver will test the health policy impacts of the federal law that are scheduled to take effect in 2014, including crowd-out policies, cost-sharing requirements, income determination methods, adverse selection provisions, the relevance of Transitional Medicaid and the impact of real-time eligibility on verification requirements and retroactive and presumptive determinations.

The Medicaid 2014 Waiver will align BadgerCare Plus crowd-out provisions with this policy to test whether or not young adults subsequently enroll in their parents plan and maintain access to health coverage.

The waiver will demonstrate the impact of cost-sharing provisions on lower-income families above the poverty line. Will participants pay? Will the cost-sharing requirements slow the growth of health care spending? The demonstration will consider policy choices related to the alignment of benefits and the equity of cost-share provisions for Medicaid, the Basic Health Plan and subsidized insurance.

The Wisconsin 2014 Waiver proposes to demonstrate how ending transitional Medical Assistance (TMA) interacts with an environment where low-cost coverage is otherwise available to individuals.

The waiver will evaluate the impact of restrictive re-enrollment policies on premium payment compliance and the overall PMPM for BadgerCare Plus members in populations subject to this policy.

The Medicaid 2014 waiver will test the impact of replacing retroactive and presumptive eligibility policies with a real-time, online application system designed to facilitate immediate access to Wisconsin's health care safety net.

The waiver will test the significance of household income resources not considered by MAGI rules. Is the income of other adults living in the household significant to the determination of eligibility for Medicaid?

The Medicaid 2014 Waiver provides the federal government with a budget neutral way to pilot policies related to Medicaid and the implementation of PPACA. Indeed, the provisions of this waiver are projected to not only further policy insights in order to achieve the best possible transition to 2014, but they generate savings for state and federal taxpayers as well.

To that end, this proposal requests waiving several provisions of federal law, including PPACA's own maintenance of effort (MOE) requirements. MOE flexibility is critical to the success of this demonstration because it facilitates testing ideas about the interaction between Medicaid and other health policies in PPACA.

The attached table reflects details of what provisions will be applied to whom for this demonstration.

Two existing Wisconsin 1115 waivers are affected by this proposal. The state is requesting to amend both our childless adults' demonstration waiver 11-W-00242/5 and our BadgerCare waiver 11-W-00125/5 to better align the policies contained therein with this Medicaid 2014 waiver. Wisconsin looks forward to partnering with CMS to enact this important demonstration project.

We are requesting authority to maintain the Wisconsin Medicaid 2014 waiver through December 31, 2013, the same sunset date currently scheduled for both the BadgerCare and Core waivers.

V. Waivers and Authority Requested

This demonstration program requires waivers from Titles XIX and XXI of the Social Security Act (the Act).

Wisconsin requests that the Secretary waive all relevant Medicaid and Children's Health Insurance Program (CHIP) laws and regulations which would allow Wisconsin to receive federal matching funds as described below. Wisconsin may also request waiving other Medicaid and CHIP laws and regulations not specified below to the extent we become aware that waiving additional citations would be necessary to implement the proposed demonstration program.

A. Demonstration Populations

Demonstration Population 1: pregnant women and non-disabled children < age 1 year.
Demonstration Population 2: non-disabled children ages 1 year through 5 years.
Demonstration Population 3: non-disabled children ages 6 through age 18 years.
Demonstration Population 4: parents and caretakers (age 19 years and older) who do not have a disability.

B. Expenditure Authority

a. Wisconsin requests that, under the authority of sections 1115(a)(1) and 2107(e)(2)(A) of the Act, expenditures for the items identified below be regarded as expenditures under Wisconsin's Medicaid and CHIP State Plans. These are the exceptions to Medicaid and CHIP requirements for the demonstration populations:

1. Wisconsin requests a waiver of sections 1902(a)(74), 2105(d)(3) and 1902(a)(8), 1902(a)(10) and 1902(a)(17) of the Act to allow Wisconsin to restrict Medicaid and CHIP eligibility for anyone who has access to

employer sponsored major medical insurance in which the monthly premium that the employee pays does not exceed 9.5% of the family's income as described in detail below. Wisconsin requests this change for children in Demonstration Population 1, 2 and 3, where family income exceeds 133% of the federal poverty level. Wisconsin also requests this change for Demonstration Populations 4 where family income exceeds 100% of the federal poverty level, but does not exceed 150% of the federal poverty level.

Specifically, the State requests authority to impose a period of ineligibility for individuals in the affected population:

(a) Who have had access to employer-sponsored major medical health insurance (individual or family) in which the premium paid by the employee does not exceed 9.5 percent of the family's income in the previous 12 months from a household member's current employer, subject to the good cause exceptions in subparagraph (c), or
(b) Who will have access to the aforementioned insurance in subparagraph (a) from a household member's current employer in the 3 calendar months following:
    i. The month in which they apply for Medicaid, or
    ii. The month in which the State is conducting the annual redetermination of Medicaid eligibility, or
    iii. The month in which the household member begins employment.
(c) Exceptions to the aforementioned conditions defined in subparagraph (a) include:
    i. Loss of employment;
    ii. Discontinuation of health benefits to all employees by the client's employer; or
    iii. During the time period when the employee failed to enroll in the health insurance coverage, one or more members of the individual's family was covered through:
        1) A private health insurance policy; or
        2) Medicaid, or CHIP, unless the eligible parent had a family income at or above 100 percent of the Federal poverty level, or the eligible child had a family income above 133 percent of the Federal poverty level.

NOTE: Wisconsin does not need federal MOE relief for the non-disabled, non-pregnant adults with income greater than 133% of the federal poverty level in order to impose this requirement.

2. Wisconsin requests a waiver of sections 1902(a)(74), 2105(d)(3), 1902(a)(8), 1902(a)(10) and 1902(a)(17) of the Act to allow Wisconsin to restrict Medicaid and CHIP eligibility for anyone who has coverage under major medical insurance in which the monthly premium that the family pays does not exceed 9.5% of the family's income. Wisconsin requests this change for children in Demonstration Populations 1, 2 and 3 where family income exceeds 133% of the federal poverty level. Wisconsin also requests this change for Demonstration Populations 4 where family income exceeds 100% of the federal poverty level, but does not exceed 150% of the federal poverty level.

   Specifically, the State requests authority to impose a period of ineligibility for individuals in the affected population:

   (a) Who currently have coverage under major medical health insurance, either through an employer or privately purchased, in which the monthly premium that the family pays does not exceed 9.5% of the family's income (individual or family), or
   (b) Who have had coverage to the aforementioned insurance in subparagraph (a), in the previous 3 months, subject to the good cause exceptions in subparagraph (c),
   (c) Exceptions to the aforementioned conditions defined in subparagraph (b) include:
      i. Health insurance was lost during the 3 month period for employment related reasons, including:
         I. Involuntary termination of employment;
         II. Voluntary termination due to the incapacitation or health condition of the individual or that of an immediate family member. An immediate family member is defined as a spouse, child or parent;
         III. The individual changed employers and the new employer does not offer health insurance coverage.
         IV. Employer discontinued health plan coverage for all employees.
      ii. Coverage was lost due to the death or change in marital status of the policy holder;
      iii. The Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage continuation period expired during the 12 month period.
      iv. The insurance is owned by someone not residing with the family and continuation of the coverage is beyond the family's control.
      v. The insurance only covers services provided in a service area that is beyond a reasonable driving distance.

NOTE: Wisconsin does not need federal MOE relief for the non-disabled, non-pregnant adults with income greater than 133% of the federal poverty level in order to impose this requirement.

3. Wisconsin requests a waiver of sections 1902(a)(74), 1902(a)(8), 1902(a)(10) and 1902(a)(17) of the Act to allow Wisconsin to restrict Medicaid eligibility for adults under age 26 who have access to major medical coverage under their parents' employer sponsored health insurance. Wisconsin requests this change for pregnant women in Demonstration Population 1 where family income exceeds 100% of the federal poverty level. Wisconsin also requests this change for parents and caretakers in Demonstration Population 4, where family income exceeds 100% of the federal poverty level, but does not exceed 150% of the federal poverty level.

Specifically, the State requests authority to impose a period of ineligibility for individuals in the affected population:

(a) Who currently have, or in the past 12 months, did have access to their parent's employer sponsored major medical health insurance, from their parent's current employer, subject to the good cause exceptions in subparagraph (b), or
(b) Exceptions to the aforementioned conditions defined in subparagraph (a) include:
    i. Loss of employment;
    ii. Discontinuation of health benefits to all employees by the parent's employer;

NOTE: Wisconsin does not need federal MOE relief for the non-disabled, non-pregnant adults with income greater than 133% of the federal poverty level in order to impose this requirement.

4. Wisconsin requests a waiver of sections 1902(a)(74), 1902(a)(14) and 1916A(b)(3)(A)(i) of the Act to allow Wisconsin to charge premiums to children with incomes between 150 and 185% of the federal poverty level in a mandatory group. This applies to Demonstration Population 2.

5. Wisconsin requests a waiver of sections 1902(a)(74), 2105(d)(3), 1902(a)(8), 1902(a)(10), 1902(a)(14) and 1902(a)(17) of the Act to allow Wisconsin to restrict Medicaid and CHIP eligibility for twelve months for

anyone who has refused to pay a BadgerCare Plus premium or has been terminated for failure to pay a BadgerCare Plus premium. This applies to children in Demonstration Populations 1, 2, and 3 with incomes greater than 150% of the federal poverty level.

6. Wisconsin requests a waiver of sections 1902(a)(74), 2105(d)(3), 1902(a)(17)(D) of that Act to allow Wisconsin to include the income of all adults residing in the same household for at least 60 days, except grandparents not applying for or receiving Medicaid with the children (i.e., a three generation case), in determining the Medicaid and CHIP eligibility of individuals in Demonstration Populations 1, 2, and 3. Wisconsin also requests a waiver for Demonstration Population 4 with incomes up to 150% of the federal poverty level. This change does not extend to including the financial needs of the other adults as it pertains to household size for the determination of eligibility.

   NOTE: Wisconsin does not need federal MOE relief for the non-disabled, non-pregnant adults with income greater than 133% of the federal poverty level in order to impose this requirement.

7. Wisconsin requests a waiver of sections 1902(a)(74) and 1902(a)(34) of that Act to allow Wisconsin to end backdating eligibility for individuals who meet all Medicaid requirements in the three months prior to the application month. This would be applied to Demonstration Populations 1, 2, and 3. Wisconsin also requests a waiver for Demonstration Population 4 with incomes up to 150% of the federal poverty level.

   NOTE: Wisconsin does not need federal MOE relief for the non-disabled, non-pregnant adults with income greater than 133% of the federal poverty level in order to impose this requirement.

8. Wisconsin requests a waiver of sections 1902(a)(52), (63), (74) and 1902(e)(1) of that Act to allow Wisconsin to end:

   - 12 months of Transitional Medical Assistance (TMA) for families when earnings cause them to lose eligibility for Medicaid under section 1931,

   - 4 months of TMA for families when earnings cause them to lose eligibility for Medicaid under section 1902(e)(1), and

- 4 months of TMA for families when child support income cause them to lose eligibility for Medicaid under section 1931.

This would be applied to Demonstration Populations 1, 2, 3, and 4.

b. Wisconsin requests that, under the authority of section 1115(a)(1) and 2107(e)(2)(A) of the Act, expenditures for the items identified below be regarded as expenditures under Wisconsin's Medicaid and CHIP State Plans. The following items include those eligibility requirements that would be allowed under Wisconsin's Medicaid or CHIP State Plans, but for the imposition of section 1902(a)(74) and 2105(d)(3) of the Act as it applies to the Maintenance of Effort requirements of a state's programs and the claiming of federal financial participation (FFP). Wisconsin requests that we be allowed to change our policies or submit State Plan Amendments to implement the following items, and receive CMS approval without impact to the state's ability to receive FFP:

1. Provide the state with authority to establish and adjust premiums for individuals in Medicaid or CHIP with incomes above 150% of the FPL within the limits of the federal 5% of household income cost sharing cap. This applies to children in Demonstration Populations 1, 2, and 3, when family income exceeds 150% of the federal poverty level.

   NOTE: Wisconsin is requesting an 1115 waiver of 1902(a)(14) in section a. 4. above for the demonstration 2 population of children with family incomes from 150% to 185% of the federal poverty level.

2. End presumptive eligibility option for the children under Demonstration Populations 1, 2 and 3.

3. While this will not require a state plan amendment to either the Medicaid or CHIP State Plans, Wisconsin requests that the termination or reduction of existing eligibility be effective on the date ten days after adequate notice of an adverse action, rather than the current practice of ending or reducing eligibility at the end of the calendar month after a ten day notice has been provided. This would apply to Demonstration Populations 1, 2, and 3. This would also apply to Demonstration Population 4 with incomes up to 133% of the federal poverty level.

4. While this will not require a state plan amendment to either the Medicaid or CHIP State Plans, Wisconsin requests that we be allowed to require applicants and recipients to verify residence in the State of

Wisconsin. This applies to Demonstration Populations 1, 2, and 3. This would also apply to Demonstration Population 4 with incomes up to 133% of the federal poverty level. In the case of children under Demonstration Populations 1, 2 and 3, this requirement means that the child's parent or caretaker relatives would supply proof of intent to reside in Wisconsin.

Separately, the state is also filing proposed amendments to the Core childless adults waiver #11-W-00242/5 and the BadgerCare waiver #11-W-00125/5 seeking authority to better align the eligibility rules of those waivers to the Medicaid 2014 waiver.

Part VI: Public Input

The ideas for many of the efficiencies included in Wisconsin's Medicaid 2014 waiver reflect extensive public input gathered through Town Hall meetings held by DHS at locations throughout the state earlier this year.

DHS submits the Medicaid 2014 waiver after public hearing by the Legislature's Joint Committee on Finance, pursuant to direction of the Legislature in enactment of the 2011-13 budget.

On September 30, 2011 DHS posted specific information about this waiver on the Department website with an opportunity for public comment. In addition, DHS held public hearings on this and other Medicaid efficiencies provisions in Madison and Milwaukee on October 19 and 21, 2011.

Along with the website available to them, DHS separately solicited the input of Wisconsin tribes through letters sent on October 14, 2011 and during a meeting held on October 25 between DHS and tribal representatives.

Part VII. Evaluation

Wisconsin will conduct an external evaluation to test the impact of certain provisions of the Patient Protection and Affordable Care Act (PPACA) on Medicaid.

The evaluation will be developed in partnership with the University of Wisconsin Population Health Institute within the UW School of Medicine and Public Health. The Institute has been involved in the design of BadgerCare Plus and is currently evaluating the program expansion to all children, parents and pregnant women. Specific research questions being considered for the Medicaid 2014 waiver include:

<u>Program Impact Questions</u>

1. Is 9.5% of household income a reasonable threshold for affordability? Do members follow-through with maintaining coverage at the expected levels of cost sharing?

2. Do young adults enroll in their parent's major medical insurance policy as a result of the waiver's crowd-out restrictions for this population?

3. Do additional cost sharing requirements lower the growth rate of health care costs? Why or why not?

4. Does ending transitional medical assistance (TMA) create barriers to re-employment when coverage options exist at income levels that are at least twice the TMA income limit?

5. Do enhanced restrictive re-enrollment policies impact premium payment compliance and overall program per-member per-month costs?

6. Does a real-time eligibility system lessen the need for retroactive and presumptive eligibility policies?

7. How can back-end verification processes work effectively with online real-time eligibility to assure both efficiency and program integrity in Medicaid?

8. Does MAGI comprehensively capture household resources in light of the data collected under the authority of this waiver to consider the income of all adults living in the household?

9. Does the program lead to more continuous care and reduce churning as compared to the GAMP population experience?

VIII. Budget

The budget neutrality documents have been attached to this waiver proposal

RE: Wisconsin BadgerCare Plus Health Insurance 1115 Demonstration Waiver, **Waiver 11-W-00125/5**

Per the terms of Wisconsin's approved 1115 demonstration waiver (11-W-00125/5) that includes the population of categorically needy parents and caretaker relatives who would be eligible for Medicaid under Wisconsin's Medicaid state plan under section 1902(a)(10)(A)(ii)(I) of the Act, who are not pregnant and whose countable income is at or above 150% of the FPL, up to and including 200% FPL, the State of Wisconsin is writing to request the following modifications to the Special Terms and Conditions (STCs) that were last amended and approved effective January 1, 2011.

Modification to Section V, Item 15

This amendment modifies the insurance crowd out provisions applied to the demonstration population as follows:

Under this demonstration, the State may exclude from eligibility under the State plan the following individuals who:

1. Have access to employer sponsored major medical insurance in which the monthly premium that the employee pays does not exceed 9.5% of the family's income as described in detail below.

Specifically, the State requests authority to impose a period of ineligibility for individuals in the affected population:

(a) Who have or have had access to employer-sponsored major medical health insurance (individual or family) in which the premium paid by the employee does not exceed 9.5 percent of the family's income in the previous 12 months from a household member's current employer, subject to the good cause exceptions in subparagraph (c), or

(b) Who will have access to the aforementioned insurance in subparagraph (a) from a household member's current employer in the 3 calendar months following:
i. The month in which they apply for Medicaid, or
ii. The month in which the State is conducting the annual redetermination of Medicaid eligibility, or
iii. The month in which the household member begins employment.

(c) Exceptions to the aforementioned conditions defined in subparagraph (a) include:
i. Loss of employment;
ii. Discontinuation of health benefits to all employees by the client's employer; or

iii. During the time period when the employee failed to enroll in the health insurance coverage, one or more members of the individual's family was covered through:

1) A private health insurance policy; or

2) Medicaid, or CHIP, unless the eligible parent had a family income at or above 100 percent of the Federal poverty level of the eligible child had a family income at or above 133 percent of the Federal poverty level.

2. Have coverage under major medical insurance in which the monthly premium that the family pays does not exceed 9.5% of the family's income.

Specifically, the State requests authority to impose a period of ineligibility for individuals in the affected population:

(a) Who currently have coverage under major medical health insurance, either through an employer or privately purchased, in which the monthly premium that the family pays does not exceed 9.5% of the family's income (individual or family), or

(b) Who have had coverage to the aforementioned insurance in subparagraph (a), in the previous 3 months, subject to the good cause exceptions in subparagraph (c),

(c) Exceptions to the aforementioned conditions defined in subparagraph (b) include:

i. Health insurance was lost during the 3 month period for employment related reasons, including:

I. Involuntary termination of employment;

II. Voluntary termination due to the incapacitation or health condition of the individual or that of an immediate family member. An immediate family member is defined as a spouse, child or parent;

III. The individual changed employers and the new employer does not offer health insurance coverage.

IV. Employer discontinued health plan coverage for all employees.

ii. Coverage was lost due to the death or change in marital status of the policy holder;

iii. The Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage continuation period expired during the 12 month period.

iv. The insurance is owned by someone not residing with the family and continuation of the coverage is beyond the family's control.

v. The insurance only covers services provided in a service area that is beyond a reasonable driving distance.

3. Are under age 26 and have access to major medical coverage under their parents' employer sponsored health insurance.

   Specifically, the State requests authority to impose a period of ineligibility for individuals in the affected population:

   (a) Who currently have or have had access to their parent's employer sponsored major medical health insurance in the previous 12 months, from their parent's current employer, subject to the good cause exceptions in subparagraph (b), or
   (b) Exceptions to the aforementioned conditions defined in subparagraph (a) include:
      i. Loss of employment;
      ii. Discontinuation of health benefits to all employees by the parent's employer;

Additionally, the State requests authority to broaden the BadgerCare waiver to include the following provisions:

Wisconsin requests a waiver of sections 1902(a)(74), 2105(d)(3), 1902(a)(8), 1902(a)(10), 1902(a)(14) and 1902(a)(17) of the Act to allow Wisconsin to restrict Medicaid and CHIP eligibility for twelve months for anyone included in this demonstration who has refused to pay a BadgerCare Plus premium or has been terminated for failure to pay a BadgerCare Plus premium.

Wisconsin requests a waiver of sections 1902(a)(74), 2105(d)(3), 1902(a)(17)(D) of that Act to allow Wisconsin to include the income of all adults residing to in the same household for at least 60 days, except grandparents not applying for or receiving Medicaid with the children (i.e., a three generation case), in determining the eligibility of anyone in this demonstration. This change does not extend to including the financial needs of the other adults as it pertains to household size for the determination of eligibility.

These provisions may be added as amendments to Section V, Item #15 of the Special Terms and Conditions.

Revised Budget Neutrality Assessment

See attached chart for projected, all funds and federal funds, impact of the benefit modifications.

RE: Wisconsin BadgerCare Plus Health Insurance for Childless Adults Section 1115 Demonstration Waiver, **Waiver 11-W-00242/5**

Per the terms of Wisconsin's approved 1115 demonstration waiver (11-W-00242/5) extending Medicaid coverage to uninsured childless adults, the State of Wisconsin is writing to request the following modifications to the Special Terms and Conditions (STCs) that were last amended and approved effective July 1, 2010.

Modification to Section IV, Item 17(f)

This amendment modifies the definition of household income by adding the following language to Section IV, item 17(f):

Income is defined as the total income of all adults residing in the household for at least 60 days. For purposes of determining income eligibility by household size, the household composition includes the applicant and, if applicable, his or her spouse.

Modification to Section IV, Item 17(m)

This amendment adds monthly premium requirements for eligible individuals with incomes between 150% and 200% FPL by adding the following language to Section IV, item 17(m):

Individuals with incomes between 150% and 200% FPL are required to pay a monthly premium that shall not exceed 5% of the individual's household income. Failure to meet this premium requirement will result in twelve months of restrictive re-enrollment. Premiums will be in addition to copayment and application fee requirements established in STC item 28. The total amount of all combined copayments, premiums and application fees shall not exceed 5% of the household income of the applicant or recipient.

Modification to Section IV, Item 17

This amendment waives maintenance of effort requirements for certain eligibility procedures and methods by adding the following paragraph (not lettered) to the end of item 17:

Additionally, maintenance of effort provisions required under Section 1902(a)(74) of the Social Security Act shall be waived for the following eligibility procedures and methods:

1) *Verification of Residency – Eligibility procedures shall be modified to require each applicant, both at the time of initial application and at each required eligibility renewal, to provide verification of their state residency.*
2) *Eligibility End Date – Eligibility procedures shall be modified to end eligibility ten days after adequate notice of adverse action. This replaces the current*

practice of ending eligibility on the last day of the calendar month after a ten day notice has been provided.

3) *Income Methodology – As identified in the proposed amendment to Section IV, Item 17(f), eligibility methods shall be modified related to determination of income. Income will be defined as the total income of all adults living in the household. For purposes of determining income eligibility by household size, the household composition includes the applicant and, if applicable, his or her spouse.*

Modification to Section V, Item 28

This amendment adds premiums to the cost sharing requirements for eligible individuals with incomes between 150% and 200% FPL by adding the following language to Section V, item 28:

Individuals with incomes between 150% and 200% FPL are requested to pay a monthly premium that shall not exceed 5% of the individual's household income.

Revised Budget Neutrality Assessment

See attached chart for projected, all funds and federal funds, impact of the benefit modifications.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

d. Enforcement

Applies only to: i. Newborns who are deemed eligible under 1902(e)(4) and were born to women with family incomes of 200 to 300% of the Federal income poverty line, whose eligibility was determined under 1902(a)(10)(A)(ii) or 1902(a)(10)(C); ii. Infants with incomes from 200 through 300% of the official Federal income poverty line, under 1902(a)(10)(A)(ii)(IX).

1. _X/ Providers are permitted to require, as a condition for the provision of care, items, or services, the payment of any cost sharing.

2. _X/ (If above box selected) Providers permitted to reduce or waive cost sharing on a case-by-case basis.

3. State payments to providers must be reduced by the amount of the beneficiary cost sharing obligations, regardless of whether the provider successfully collects the cost sharing.

4. States have the ability to increase total State plan rates to providers to maintain the same level of State payments when cost sharing is introduced.

2. Premiums

a. __/ No premiums are imposed.

b. X_/ Premiums are imposed under section 1916A of the Act as follows (specify the premium amount by group and income level.

Group of Individuals	Premium*	Method for Determining Family Income (including monthly or quarterly period)
Parents and caretaker relatives 1902(a)(10)(A)(ii) With incomes above 150% and at or below 200% of the official Federal poverty line income (FPL) Infants 1902(a)(10)(A)(ii)(IX) With incomes from 150% through 300% of the FPL Children 1902(a)(10)(A)(i)(VI) With incomes above 150% through 185% of the FPL	Countable income — Premium Amount Above 150% - 159.99% FPL: .... 5% of 150% FPL 160% - 169.99% FPL: ..... 5% of 160% FPL 170% - 179.99% FPL: ..... 5% of 170% FPL 180% - 189.99% FPL: ..... 5% of 180% FPL 190% - 199.99% FPL: ..... 5% of 190% FPL 200% - 209.99% FPL: ..... 5% of 200% FPL 210% - 219.99% FPL: ..... 5% of 210% FPL 220% - 229.99% FPL: ..... 5% of 220% FPL 230% - 239.99% FPL: ..... 5% of 230% FPL 240% - 249.99% FPL: ..... 5% of 240% FPL 250% - 259.99% FPL: ..... 5% of 250% FPL 260% - 269.99% FPL: ..... 5% of 260% FPL 270% - 279.99% FPL: ..... 5% of 270% FPL 280% - 289.99% FPL: ..... 5% of 280% FPL 290% - 300.00% FPL: ..... 5% of 290% FPL	The methodology used to determine family income is the same as the methodology used to determine eligibility, except that depreciation expenses are added back in.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

* Premium calculations shown in the previous table are reduced as described below when the household is paying premiums for major medical health insurance for other members of the Medicaid/CHIP household.

Household income	Medicaid Premium Reduction Amount
Above 150% FPL up to 200% FPL	50%, not to exceed other premium amount paid
Above 200% FPL up to 250% FPL	33%, not to exceed other premium amount paid
Above 250% FPL up to 300% FPL	20%, not to exceed other premium amount paid

b. Limitation:

- The total aggregate amount of premiums and cost sharing imposed for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a monthly or quarterly basis as specified by the State above.

Supersedes
TN No. 08-025

Approval Date _____

Effective Date: _____

STATE: Wisconsin

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation	Group Covered
	B. Optional Coverage Other Than the Medically Needy (Continued)
1920A of the Act	___ 24. Presumptive Eligibility for Children Children under age 19 who are determined by a qualified entity (as defined in 1920A(b)(3)(A)) based on preliminary information, to meet the highest applicable income criteria specified in this plan. The presumptive period begins on the day that the determination is made. If an application for Medicaid Is filed on the child's behalf by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on the day that the state agency makes a determination of eligibility based on that application. If an application is not filed on the child's behalf by the last day of the month following the month the determination of presumptive eligibility was made, the presumptive period ends on that last day.

Supersedes
TN No. 07-007

Approval Date:_____

Effective Date:_____

2.3 Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. *(Previously 4.4.5)* **(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42 CFR 457.80(c))**

Applicants are eligible for BadgerCare Plus if they meet all of the following conditions:

- **They are not currently enrolled in any group or individual health insurance plan as defined in HIPAA.**
- **They have not been enrolled in a group or individual health plan meeting HIPAA criteria during the past six months.**
- **They have not had access to a State employee's health benefits plan in the previous 12 months.**
- **They have not had access to a group or individual health insurance plan in the previous 12 months in which the amount they pay for premiums is no more than 9.5% of their household income.**

Good cause is granted to family members of those individuals who have been or are currently covered, if the individual, through whom the insurance was available, has involuntarily lost their job with the employer providing that insurance, or the employee pays more than 9.5% of their household income for employer health insurance coverage;
Persons who *have access* to employer health insurance that meets HIPAA standards and for which the employer pays *at least 40 % of the cost* will be eligible for the health insurance premium purchase under BadgerCare Plus to assure that BadgerCare Plus does not substitute for private coverage. These provisions apply to the SCHIP expanded population only.

In families, where the state purchases employer subsidized family group health plan for a household that includes both Medicaid funded and SCHIP funded members, we will prorate the cost of the plan based upon the number of members in the family who are funded through SCHIP and the members funded through Medicaid. For example, if a family with a mother and two children, ages seven and nine, applies for BadgerCare Plus and we determine that their family income is 130% of the FPL, we will check with their employer to determine if we should enroll them in HIPP. If their family premium is $99 per month and that proves to be cost effective, the Department will purchase their employer's group health plan for the family and say that $66 of the premium that is intended for the two children will come from SCHIP and $33 will come from Medicaid funds.

The Department will comply with the applicable SCHIP premium assistance rules when determining whether the Department will pay for the employee portion of an employer-subsidized health insurance plan that covers SCHIP children.

Section 4. Eligibility Standards and Methodology. **(Section 2102(b))**

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section 5.

4.1 The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42 CFR 457.305(a) and 457.320(a))**

4.1.1 ☒ Geographic area served by the Plan:

Statewide.

4.1.2 ☒ Age:

Separate SCHIP:

Children from age 1 through age 5 with family income above 185% FPL up to and including 300%FPL and

Children ages 6 through age 18 with family income above 150% FPL up to and including 300% FPL

Unborn children from conception to birth up to and including 300% FPL.

Medicaid Expansion:

Children ages 6 through 18 with family income from above 100%FPL up to and including 150% FPL.

4.1.3 ☒ Income:

Wisconsin has a 300% of the Federal poverty level household gross income test without any deductions. "Household gross income" includes the income of all adults residing in the home for at least 60 days, except for grandparents if they are not applying for or receiving Medicaid with the children (i.e., a three generation case). Financial needs of adults whose income is being counted are not considered unless they are legally responsible for the child.

4.1.4 ☐ Resources (including any standards relating to spend downs and disposition of resources):

There is no resource test.

4.1.5 ☒ Residency (so long as residency requirement is not based on length of time in state):

Be physically present in Wisconsin with the intent to reside in the state.

4.1.6 ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

Not applicable.

4.1.7 ☒ Access to or coverage under other health coverage:

Unborn Children

May not be covered under a group health plan or under health insurance coverage, as defined in section 2791 of the Public Health Service Act during the month of application or in the previous three calendar months, unless a good cause exemption is granted.

May not have access to a State employee's health benefits plan or to an employer's group or individual health insurance plan in the month of application or in the three calendar months following the month of an application, annual review or the start of new employment, or in the previous 12 months, unless a good cause exemption is granted.

A good cause exemption is granted to those unborn children with past or present coverage or access to a health insurance or a group health plan, if the insurance only covers services provided in a service area that is beyond a reasonable driving distance from the individual's residence.

A good cause exemption is granted to those individuals who were covered by a group health plan or health insurance coverage in the three months prior to application, if insurance did not pay for pregnancy-related services or if:

- **The individual through whom the insurance was available**

involuntarily lost their job with the employer providing that insurance, or voluntarily ended their job because of the incapacitation of the individual or because of an immediate family member's health condition,

- **Employment of the individual through whom the insurance was available changed and the new employer does not offer health insurance coverage, or the employer discontinued health plan coverage for all employees**
- **COBRA continuation coverage was exhausted in accordance with federal regulations,**
- **Coverage was lost due to the death or change in marital status of the policy holder, or**
- **The insurance was provided by someone not residing with the unborn child;**

A good cause exemption is granted to individuals with current, future or past access to an employer's group health plan, if the available insurance is through a person who is not a member of the unborn child's household or the household's share of the premium exceeds 9.5% of household income.

A good cause exemption is granted to those unborn children who, in the past 12 months, had access to a group health plan or had access to access to a State employee's health benefits plan if:

- **Employment of the individual through whom the insurance was available ended, or the employer discontinued health plan coverage for all employees; or**
- **At the time the individual failed to enroll in the employer's health insurance coverage, one or more members of the individual's family were covered through:**
  - **A private health insurance policy, or had Medicaid, unless the eligible parent had a family income above 100% of the FPL, or the eligible child had an income above 133% of the FPL, and**
  - **No one in the family was covered through CHIP.**

<u>Children covered under Separate SCHIP</u>

May not be covered under a group health plan or under health insurance coverage, as defined in section 2791 of the Public Health Service Act, during the month of application or in the previous three months, unless a good cause exemption is granted.

May not have access to a State employee's health benefits plan or to an employer's group health plan at the time of application or within the three calendar months following the month of an application, annual review or the start of new employment, or in the previous 12 months, unless a good cause exemption is granted.

A good cause exemption is granted to those children who are covered by health insurance or a group health plan during the month of application or in the previous three months, if the individual is covered by health insurance:

- **That only covers services provided in a service area that is beyond a reasonable driving distance from the individual's residence,**
- **Provided by someone who is not a member of the child's household, or**
- **Which is not a group health plan, or for which the employee's contribution exceeds 9.5% percent of the household's income. This reason does not apply to State employee's health benefits plan.**

A good cause exemption is granted to those children who were covered by a group health plan in the three months prior to application, if:

- **The individual through whom the insurance was available involuntarily lost their job with the employer providing that insurance, or voluntarily ended their job because of the incapacitation of the individual or because of an immediate family member's health condition,**
- **Employment of the individual through whom the insurance was available changed and the new employer does not offer health insurance coverage, or the employer discontinued health plan coverage for all employees, or**
- **Coverage was lost due to the death or change in marital status of the policy holder.**

A good cause exemption is granted to individuals with current, future or past access to an employer's group health plan, if the available insurance is through a person who is not a member of the child's household or for which the employee's contribution exceeds 9.5% percent of the household's income. The percentage of employee contribution is not applicable for the State employee's health plan.

A good cause exemption is granted to those individuals who, in the past 12 months, had access to a group health plan or a State employee's health

benefits plan, if:

- **Employment of the individual through whom the insurance was available ended, or the employer discontinued health plan coverage for all employees; or**
- **The individual through whom the insurance was available failed to enroll in the employer's health insurance coverage because one or more members of the individual's family were covered through:**
  - **A private health insurance policy, or had Medicaid, unless the eligible parent had a family income above 100% of the FPL, or the eligible child had an income above 133% of the FPL, and**
  - **No one in the family was covered through CHIP.**

Other good cause exemptions, consistent with the above reasons, may be approved by the Department of Health Services on a case by case basis.

4.1.8 ☒ Duration of eligibility:

Eligibility lasts until the birth of the baby for unborn children covered under SCHIP and for 12 months or until determined ineligible for all other children.

4.1.9 ☒ Other standards (identify and describe):

An SSN is not required for non-qualifying immigrants, but is required for all others.

Wages and availability of employer-sponsored health insurance must be verified by the employer.

4.2 The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)) (42 CFR 457.320(b))**

4.2.1 ☒ These standards do not discriminate on the basis of diagnosis.

4.2.2 ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3 ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3 Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2)) (42 CFR 457.350)**

The methods of establishing eligibility and continuing enrollment are the same as under Title XIX.

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). **(Section 2106(b)(7)) (42 CFR 457.305(b))**

☒ Check here if this section does not apply to your state.

4.4 Describe the procedures that assure that:

4.4.1 Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. **(Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42 CFR 457.350(a)(1)) 457.80(c)(3))**

Eligibility is determined in Wisconsin's automated eligibility system, CARES. CARES determines eligibility and benefits for Medicaid, BadgerCare Plus, SeniorCare, Food Stamp, and TANF (Wisconsin Works, Child Care and SSI Caretaker Supplement) programs. In determining eligibility for Medicaid and BadgerCare Plus, CARES will configure the group, check nonfinancial factors of eligibility, add together the appropriate financial resources of the group and determine eligibility, regardless of whether the individual would be Medicaid or BadgerCare Plus eligible. Once eligibility is determined, CARES checks nonfinancial factors, whether the individual is a child (under age 6 or age 6 to under age 19), parent, adult caretaker relative or pregnant woman and then determines which the federal poverty level for the individual based upon the family's income and size. CARES then assigns a medical status code, which indicates whether the individual's benefit and administrative costs are Title 19, or Title 21 or 100% state funded, for MMIS and MSIS.

4.4.2 The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. **(Section 2102)(b)(3)(B)) (42 CFR 457.350(a)(2))**
See 4.4.1

4.4.3 The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42 CFR 431.636(b)(4))**

Any applicant or enrollee who is found ineligible for Medicaid services (based on the eligibility of his or her mother) and appears eligible for the separate child health program is automatically reviewed for SCHIP eligibility.

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. **(Section 2102)(b)(3)(C)) (42 CFR 457.805) (42 CFR 457.810(a)-(c))**

4.4.4.1 ☒ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

Persons who are covered by employer health insurance plans that meet the Health Insurance Portability and Accountability Act (HIPAA) standards (and have not demonstrated good cause) will not be eligible for BadgerCare Plus. The eligibility worker will collect insurance information from the household to verify coverage and access. The HIPAA standard will be included in a question to the applicant family asking whether this is a major medical health insurance plan. EDS, Wisconsin Medicaid's fiscal agent, will then verify coverage through the eligibility exchange system currently in use, and through written and phone contacts with employers. When previously unreported insurance coverage is discovered, EDS will inform the worker who will close BadgerCare Plus coverage.

Persons who *have coverage* under employer health insurance that meets HIPAA are ineligible for BadgerCare Plus, unless they are able to demonstrate good cause. Persons who *have access* to employer health insurance that meets HIPAA standards and for which the premiums the employee pays is 9.5% or less of the household's income are also ineligible for BadgerCare Plus. Persons who *have access* to employer health insurance that meets HIPAA standards and for which the employer pays *at least 40 % of the premium and the employee would pay in excess of 9.5% of household income for his/her share of the premium* will be eligible for the health insurance premium purchase under BadgerCare Plus to assure that BadgerCare Plus does not substitute for private coverage.

4.4.4.2 ☒ Coverage provided to children in families over 200% and up to 300% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

As part of the 2003-2005 Biennial Budget Act, Wisconsin implemented a

mandatory employer verification of earnings and health insurance access/coverage at:

- **Application for BadgerCare;**
- **Annual Renewal of BadgerCare;**
- **Upon entry into a new job; and,**
- **When a family moved from Medicaid to BadgerCare.**

The process involved sending a pre-printed form to recipients asking them to verify with their employer their earnings and their health insurance status. We required the employer to sign the form. When the form was returned, the information was entered into Wisconsin's automated eligibility system, CARES, where eligibility could be determined and confirmed. Within the first six months of implementation, BadgerCare enrollment dropped by 25%.

In response to this drastic change, the Department completed an evaluation and found that the most common reasons for the decrease was that employers were not completing the form that verified health insurance status and that some recipients simply did not attempt to complete the verification process. Interviews with employers revealed that they were too busy to comply and that completing the form was not a priority. Interviews with recipients revealed that they had not read the notice explaining what they needed to do or that, because of other factors in their lives, they were unable to comply. At this time, it was decided that with the 2007-2009 Biennial Budget, the Wisconsin Medicaid agency would seek a new solution.

With BadgerCare Plus, we employ a new process that does not rely on county/tribal eligibility workers or on applicant/recipients. The Department has built an employer health insurance database with all of the employers of BadgerCare Plus parents, caretakers and pregnant women. The database, which has been and will be populated using information from employers, contains information about whether the employer offers any insurance, rules for which employees have access to the benefit, the individual and family premium amount, and the amount the employer pays for the premium. At the time of application and review, when the family identifies their employer in the automated eligibility system, the system will automatically check the employer health insurance database. If the employer does not offer health insurance to anyone or offers health insurance to all, this information will be passed back to CARES and eligibility will be determined and confirmed. If the employer has rules about whom and when employees have access to their insurance and the cost of the premium that employee pays is 9.5% or less of household income for that insurance, that information will be passed back to the worker who will use it to enter data into CARES at which time eligibility can be determined and

confirmed. If the employer has not supplied complete information needed to make a determination, we (not the county or tribal eligibility worker) will contact the employer to request the information. By state law, if the employer does not supply the information within the time period allowed, usually 30 days, BadgerCare Plus eligibility will be granted and the employer will be fined an amount equivalent to the BadgerCare Plus per member per month cost until the information is supplied. (For those months, there will be no benefit cost to either the state or federal government). Employers are granted a fair hearing if they disagree with the fiscal penalty. There are maximum values for all employers that vary based upon the number of employees.

4.4.4.3 ☰ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

Wisconsin uses the same methologies indicated in Section 4.4.4.2 to monitor substitution and to prevent substitution.

4.4.4.4 ☐ If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

Wisconsin has a long-standing working relationship with tribal health directors in the State. From statewide HMO implementation, Medicaid staff met with tribal health directors over an 18-month period to coordinate HMO expansion with the needs of the tribes and with Indian Health Service responsibilities. A special disenrollment procedure was developed for tribal members that involves close coordination with Indian Health Clinics, tribal members, and the Medicaid HMO enrollment broker. A special payment system was developed so that non-HMO affiliated Indian Health Clinics could still be reimbursed by Medicaid for fee-for-service funds for services provided to tribal members enrolled in HMOs, and so that Indian Health Service funds would not be jeopardized by the expansion of the HMO program.

We continue to hold regular meetings with tribal leaders to discuss health care related issues. We intend to use these meetings to solicit input and provide

information to the tribes on BadgerCare Pus.

Section 8. Cost Sharing and Payment (Section 2103(e))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section 9.

8.1 Is cost-sharing imposed on any of the children covered under the plan? **(42 CFR 457.505)**

8.1.1 ☒ YES

8.1.2 ☐ NO, **skip to question 8.8.**

8.2 Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate. **(Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b) & (c), 457.515(a)&(c))**

8.2.1 Premiums:

Premiums will be imposed upon children with monthly family income greater than 150% FPL. The base rate is based upon family income and will not exceed 5% of monthly family income. Recipients will receive a notice telling them how much their premiums will be. Base rates for children ages 1 – 18, with
Incomes at or above 150% FPL up to, but not including 160% FPL: 5% of 150% FPL;
Incomes at or above 160% FPL up to, but not including 170% FPL: 5% of 160% FPL;
Incomes at or above 170% FPL up to, but not including 180% FPL: 5% of 170% FPL;
Incomes at or above 180% FPL up to, but not including 190% FPL: 5% of 180% FPL;
Incomes at or above 190% FPL up to, but not including 200% FPL: 5% of 190% FPL;
Incomes at or above 200% FPL up to, but not including 210% FPL: 5% of 200% FPL;
Incomes at or above 210% FPL up to, but not including 220% FPL: 5% of 210% FPL;
Incomes at or above 220% FPL up to, but not including 230% FPL: 5% of 220% FPL;
Incomes at or above 230% FPL up to, but not including 240% FPL: 5% of 230% FPL;
Incomes at or above 240% FPL up to, but not including 250% FPL: 5% of 240% FPL;
Incomes at or above 250% FPL up to, but not including 260% FPL: 5% of 250% FPL;
Incomes at or above 260% FPL up to, but not including 270% FPL: 5% of 260% FPL;
Incomes at or above 270% FPL up to, but not including 280% FPL: 5% of 270% FPL;
Incomes at or above 280% FPL up to, but not including 290% FPL: 5% of 280% FPL;
Incomes at or above 290% FPL up to, 300% FPL : 5% of 290% FPL;

In cases where the household is paying premiums for major medical health insurance for other members of the Medicaid/CHIP household we will reduce the amount of the base rates as indicated below.

Household income	Medicaid Premium Reduction Amount
Above 150% FPL up to 200% FPL	**Up to 50%, not to exceed the amount paid for the other premium**
Above 200% FPL up to 250% FPL	**Up to 33%, not to exceed the amount paid for the other premium**
Above 250% FPL up to 300% FPL	**Up to 20%, not to exceed the amount paid for the other premium**

8.2.2 Deductibles:

A $200 deductible will apply for covered dental services, except preventive and diagnostic services, provided to children ages 1 to 18 with incomes from 200 - 300% FPL. Preventive and diagnostic dental services which include oral examinations, prophylaxis and topical fluoride applications, sealants and x-rays do not apply to the deductible. The deductible applies to fillings and other restorative services. The deductible is applied lies on a per member basis and is based on Benchmark Plan maximum allowable fees and is counted towards the enrollee's 5 percent cost-sharing cumulative maximum, described in section 8.5.

8.2.3 Coinsurance or copayments:

Description of Children Affected		
	Premium	**Co-payments**
Children ages 1 - 5 with incomes >185 FPL up to and including 200% FPL	None	See Attachment 1, included at the end of Section 8
Children ages 6 - 18 with incomes > 150% FPL up to and including 200% of FPL	None	
Children ages 1 - 18 with incomes from 150 - 300% FPL	See 8.2.1	See Attachment 2, included at the end of Section 8

No cost sharing will be applied to unborn children.

8.3 Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. **(Section 2103(e)((1)(B)) (42 CFR 457.505(b))**

Outreach and application forms will include this information. Sections 2.2.1, 5.1, and 9.9 provide detailed descriptions of our outreach efforts. In addition, the State informs providers and members (beneficiaries) of allowable cost sharing amounts via Provider Updates and member Enrollment and Benefits booklet.

8.4 The state assures that it has made the following findings with respect to the cost sharing in its plan: **(Section 2103(e))**

8.4.1 ☑ Cost-sharing does not favor children from higher income families over lower income families. **(Section 2103(e)(1)(B)) (42 CFR 457.530)**

8.4.2 ☑ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. **(Section 2103(e)(2)) (42 CFR 457.520)**

8.4.3 ☑ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. **(Section 2103(e)(1)(A)) (42 CFR 457.515(f))**

8.5 Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: **(Section 2103(e)(3)(B)) (42 CFR 457.560(b) and 457.505(e))**

The Department will monitor cost sharing expenditures on a quarterly basis to identify families with income below 150% of the FPL for whom out of pocket premium and co-payment costs have reached the cap of 5% of their income.

As an interim process, we are notifying families in the Enrollment & Benefits booklet that the Department will monitor their cost sharing expenditures on a quarterly basis to identify any family with out of pocket premium and co-payment costs that exceeded 5% of their income and will issue a refund in the amount that co-payments exceeded their family limit.

Once our system enhancements our implemented, the CARES Notices of Decision will include a new section to inform the recipients of the maximum dollar amount that their families have to contribute as a share of the cost of the SCHIP/Medicaid benefits they are receiving. This maximum will be 5% of their countable income as calculated by CARES.

The Medicaid Management Information System (MMIS) will be used to track the cost sharing expenses and let providers know when copayments are to no longer be charged to the families.

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. **(Section 2103(b)(3)(D)) (42 CFR 457.535)**

The state ensures that American Indian and Alaska Native children, eligible for the separate SCHIP benefit, are excluded from cost-sharing by assigning them an eligibility

code that identifies them as such. This identifying information is retained in the Medicaid Management Information System (e.g., claims processing and eligibility file) which automatically exempts all cost-sharing.

Providers are notified of this requirement via written Updates and through the various eligibility verification methods available in the state. Families identify their children as Alaskan Natives or American Indian Tribal members through the application process.

This provision of the Separate SCHIP does not apply as Native Americans or Alaskan Natives as neither group could be considered as undocumented aliens.(explain)

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. **(42 CFR 457.570 and 457.505(c))**

Premiums

Each family is sent an invoice in the tenth day of the month prior to the month in which the premium is due. When a family does not pay their premium by the date required (the 10th of the month for which it is due), the family is sent a termination notice that indicates that they must pay the premium by the end of the calendar month or lose eligibility for those members for whom the premium is owed. If they pay by the end of the month, eligibility is not interrupted. If the family pays the premium by the end of the following month, their eligibility is restored without any gaps. However, if the family does not pay by the end of the month after the calendar month in which the premium was due, the individuals for whom the premium was owed cannot be restored to benefits until:

1. **The end of the twelfth month after which benefits were lost;**
2. **The beginning of the month following an adult caretaker's absence from the home for 30 consecutive days;**
3. **The beginning of the month in which the family's income dips below the premium requirement limit of 150% of the Federal Poverty Level; or**
4. **Immediately, if the reason the premium payment was not made was beyond the control of the family.**

Good cause reasons for not paying the BadgerCare Plus premium are:

- **Problems with the financial institution.**
- **System problem.**
- **Local agency problem.**
- **Wage withholding problem.**
- **Fair hearing decision.**

Copayments

Applies only to groups with incomes above 150% FPL, listed in Benchmark Plan:

Providers are permitted to require the payment of any cost sharing as a condition for the provision of care, items, or services. In addition, providers are permitted to reduce or waive cost sharing on a case-by-case basis.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. **(42 CFR 457.570(a))**

☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non payment of cost-sharing charges. **(42 CFR 457.570(b))**

☒ In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. **(42 CFR 457.570(b))**

☒ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42 CFR 457.570(c))**

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: **(Section 2103(e))**

8.8.1 ☒ No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4)) (42 CFR 457.220)**

8.8.2 ☒ No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. **(Section 2105(c)(5) (42 CFR 457.224)** *(Previously 8.4.5)*

8.8.3 ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. **(Section 2105(c)(6)(A)) (42 CFR 457.626(a)(1))**

8.8.4 ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1)) (42 CFR 457.622(b)(5))**

State/Territory: Wisconsin

3.1-C. Benchmark Benefit Package and Benchmark Equivalent Benefit Package (provided in accordance with 1937 of the Act and 42 CFR Part 440).

The State/Territory provides benchmark benefits:

X Provided

☐ Not Provided

States/Territories can have more than one alternative/benchmark benefit plan for different individuals in the new optional group. If the State/Territory has more than one alternative benefit plan, as in the example below, then a pre-print would need to appear for each additional Benchmark Plan title. (Ex: if the box signifying "Plan A" was checked then the remainder of the pre-print that would appear would be specific only to "Plan A". If "Plan B" was checked then the following pre-print that would appear would be a completely new pre-print that would be filled out by the State/Territory and would correlate to "Plan B" only.)

X Title of Alternative Benefit Plan A: Family Medicaid Benchmark Plan
☐ Title of Alternative Benefit Plan B
☐ Add Titles of additional Alternative Benefit Plans as needed

1. **Populations and geographic area covered**

X **a) Individuals eligible under groups other than the early option group authorized under section 1902(a)(10)(A)(i)(VIII) and 1902(k)(2)**

The State/Territory will provide the benefit package to the following populations:

X (i) Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, who will be required to enroll in a benchmark benefit plan to obtain medical assistance.

State/Territory: Wisconsin

Note: Populations listed below may not be required to enroll in a benchmark plan. The Benchmark-exempt individuals under 1937(a)(2)(B) are:

- A pregnant woman who is required to be covered under the State/Territory plan under section 1902(a)(10)(A)(i) of the Act.
- An individual who qualifies for medical assistance under the State/Territory plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for Supplemental Security Income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act.
- An individual entitled to benefits under any part of Medicare.
- An individual who is terminally ill and is receiving benefits for hospice care under title XIX.
- An individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in that institution under the State/Territory plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.
- An individual who is medically frail or otherwise an individual with special medical needs. For these purposes, the State/Territory's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in 42 CFR §438.50(d)(3), children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and or mental disabilities that significantly impair their ability to perform one or more activities of daily living.
- An individual who qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act.
- An individual with respect to whom child welfare services are made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age.
- A parent or caretaker relative whom the State/Territory is required to cover under section 1931 of the Act.
- A woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act.
- An individual who qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act.
- An individual who is only covered by Medicaid for care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.
- An individual determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs.

State/Territory: Wisconsin

For full benefit Medicaid eligibility groups included in the alternative benefit plan, please indicate in the chart below:

- Each eligibility group the State/Territory will require to enroll in the alternative benefit plan.
- Each eligibility group the State/Territory will allow to voluntarily enroll in the alternative benefit plan.
- Specify any additional targeted criteria for each included group (e.g., income standard).
- Specify the geographic area in which each group will be covered.

Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
X		Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance	Caretakers and Children above 100% FPL	Statewide
X		Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)	100-150% FPL	Statewide
X		Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)	100-185% FPL	Statewide
		Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)		
		Other mandatory categorically needy groups eligible under 1902(a)(10)(A)(i) as listed below and include the citation from the Social Security Act for each eligibility group:		
X		Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)	200-300% FPL	**Statewide**
X		Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)	150-300% FPL	Statewide
X		Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)	Caretakers 100-200% FPL	Statewide
X		Medicaid expansion/optional targeted low-income children eligible under 1902(a)(10)(A)(ii)(XIV)	Children age 6-18, 100-150% FPL	Statewide

State/Territory: Wisconsin

Chart, continued

Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
X		Other optional categorically needy groups eligible under 1902(a)(10)(A)(ii) as listed below and include the citation from the Social Security Act for each eligibility group: **Newborns who are deemed eligible under 1902(e)(4) and whose eligibility was determined under 1902(a)(10)(A)(ii) or 1902(a)(10)(C).**	150-200% FPL	Statewide

☐ (ii) The following populations will be given the option to voluntarily enroll in an alternative benefit plan. Please indicate in the chart below:

None of these groups will be given the option to voluntarily enroll in an alternative benefit plan.

- Each population the State/Territory will allow to voluntarily enroll in the alternative benefit plan.
- Specify any additional targeted criteria for each included population (e.g., income standard).
- Specify the geographic area in which each population will be covered.

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	Mandatory categorically needy low-income parents eligible under 1931 of the Act		
	Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):		
	Individuals qualifying for Medicaid on the basis of blindness		
	Individuals qualifying for Medicaid on the basis of disability		
	Individuals who are terminally ill and receiving Medicaid hospice benefits under 1902(a)(10)(A)(ii)(vii)		
	Institutionalized individuals assessed a patient contribution towards the cost of care		
	Individuals dually eligible for Medicare and Medicaid (42 CFR §440.315)		

State/Territory: Wisconsin

Chart, continued

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	Disabled children eligible under the TEFRA option - section 1902(e)(3)		
	Medically frail and individuals with special medical needs		
	Children receiving foster care or adoption assistance under title IV-E of the Act		
	Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)		
	Individuals eligible as medically needy under section 1902(a)(10)(C)(i)(III)		
	Individuals who qualify based on medical condition for long term care services under 1917(c)(1)(C)		

Limited Services Individuals

Neither of these groups will be given the option to voluntarily enroll in an alternative benefit plan.

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	TB-infected individuals who are eligible under 1902(a)(10)(A)(ii)(XII)		
	Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)		

☐ (iii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.
- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.
- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment.
  - The individual was given ample time to arrive at an informed choice.
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

State/Territory: Wisconsin

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

  Wisconsin is not offering voluntary enrollment to these individuals.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe in the below the manner in which the State/Territory will inform each individual of all of the following:

- Enrollment is voluntary.
- Each individual may choose at any time not to participate in an alternative benefit package.
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

☐ **b) Individuals eligible under the early option group authorized under sections 1902(a)(10)(A)(i)(VIII) and 1902 (k)(2)**

Note: Individuals in the early option group who are exempt from mandatory enrollment in Benchmark coverage under 1937(a)(2)(B) CANNOT be mandated into a Benchmark plan. However, State/Territories may offer exempt individuals the opportunity to voluntarily enroll in the Benchmark plan.

☐ (i) The State/Territory has chosen to offer the populations/individuals in the early option group who are exempt from mandatory enrollment in the benchmark benefit plan the option to voluntarily enroll in the benchmark benefit plan. Please specify whether the benchmark will cover these individuals Statewide/Territory-wide or otherwise.

Populations and individuals in the early option group will not be given the option to voluntarily enroll in an alternative benefit plan.

☐ (ii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment.
  - The individual was given ample time to arrive at an informed choice.
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

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State/Territory: Wisconsin

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/ benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

  Wisconsin is not offering voluntary enrollment to these individuals.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

- For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe below the manner in which the State/Territory will inform each individual of all of the following:
  - Enrollment is voluntary.
  - Each individual may choose at any time not to participate in an alternative benefit package.
  - Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

2. Description of the Benefits

X The State/Territory will provide the following alternative benefit package (check the one that applies).

a) X Benchmark Benefits

☐ **FEHBP-equivalent Health Insurance Coverage** – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(l) of Title 5, United States Code.

☐ **State/Territory Employee Coverage** – A health benefits coverage plan that is offered and generally available to State/Territory employees within the State/Territory involved.

Please provide below either a World Wide Web URL (Uniform Resource Locator) link to the State/Territory's Employee Benefit Package or insert a copy of the entire State/Territory Employee Benefit Package.

Not applicable.

State/Territory: Wisconsin

X **Coverage Offered Through a Commercial Health Maintenance Organization (HMO)** – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State/Territory involved.

X The State/Territory assures that it complies with all Managed Care regulations at 43 CFR §438.

Please provide below either a World Wide Web URL link to the HMO's benefit package or insert a copy of the entire HMO's benefit package.

See Attachment A for a copy of the HMO's benefit package.

☐ **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide below a full description of the benefits in the plan, including any applicable limitations. Also include a benefit by benefit comparison to services in the State/Territory plan or to services in any of the three Benchmark plans above.

State/Territory: Wisconsin

b) X Benchmark-Equivalent Benefits.

The State will solicit proposals from managed care organizations either to provide the HMO benefit package that has the largest insured commercial, non-Medicaid enrollment in the State, or to provide a benefit package that meets the requirements for benchmark-equivalent coverage under SSA § 1937(b)(2). In the event the State receives one or more acceptable proposals to provide a benefit package that meets the requirements for benchmark-equivalent coverage, the State will make all required assurances and showings relating to actuarial equivalence.

Please specify below which benchmark plan or plans this benefit package is equivalent to:
Coverage Offered Through a Commercial Health Maintenance Organization (HMO)

X (i) Inclusion of Required Services – The State/Territory assures the alternative benefit plan includes coverage of the following categories of services: (Check all that apply).

X Inpatient and outpatient hospital services.

X Physicians' surgical and medical services.

X Laboratory and x-ray services.

X Coverage of prescription drugs.
Prescription drugs are carved out of HMO coverage and are covered on a fee-for-service basis.

X Mental health services.

X Well-baby and well-child care services as defined by the State/Territory, including age-appropriate immunizations in accordance with the Advisory Committee on Immunization Practices.

X Emergency services.

X Family planning services and supplies.

X (ii) Additional services
Please list the additional services being provided.

Please insert below a full description of the benefits in the plan including any additional services and limitations.
The Family Medicaid Benchmark Plan covers additional benefits in the following service areas:

- Dental
- Hearing Services - hearing aids
- SLP services following a cochlear implant
- Vision - coverage of one pair of eyeglasses

State/Territory: Wisconsin

X (iii) The State/Territory assures that the benefit package has been determined to have an aggregate actuarial value equivalent to the specified benchmark plan in an actuarial report that has all of the following characteristics:

- Has been prepared by an individual who is a member of the American Academy of Actuaries.
- Uses generally accepted actuarial principles and methodologies.
- Uses a standardized set of utilization and price factors.
- Uses a standardized population that is representative of the population being served.
- Applies the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used.
- Takes into account the ability of a State/Territory to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State/Territory to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State/Territory plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

Please insert a copy of the report.

Actuarial report will be provided in the event the State receives one or more acceptable proposals to provide a benefit package that meets the requirements for benchmark-equivalent coverage.

X (iv) The State/Territory assures that if the benchmark plan used by the State/Territory for purposes of comparison in establishing the aggregate value of the benchmark-equivalent package includes any of the following two categories of services, the actuarial value of the coverage for each of these categories of services in the benchmark-equivalent coverage package is at least 75 % of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State/Territory:

- Vision services, and/or
- Hearing services

Please insert below a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

Response will be provided in the event the State receives one or more acceptable proposals to provide a benefit package that meets the requirements for benchmark-equivalent coverage.

State/Territory: Wisconsin

c) **X** Additional Benefits
If checked please insert a full description of the additional benefits including any limitations.

The Family Medicaid Benchmark Plan covers additional benefits in the following service areas:

- Dental
- Hearing Services - hearing aids
- SLP services following a cochlear implant
- Vision - coverage of one pair of eyeglasses

3. Service Delivery System

Check all that apply.

X The benchmark benefit plan will be provided on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The benchmark benefit plan will be provided on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1905(a)(25) and 1905(t). (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

X The benchmark benefit plan will be provided through a managed care organization consistent with applicable managed care requirements (42 CFR §438, 1903(m), and 1932).

☐ The benchmark benefit plan will be provided through PIHPs (Pre-paid Inpatient Health Plan) consistent with 42 CFR §438.

☐ The benchmark benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).

☐ The benchmark benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology when applicable.)

4. Employer Sponsored Insurance

X The benchmark benefit plan is provided in full or in part through premiums paid for an employer sponsored health plan.

State/Territory: Wisconsin

5. Assurances

X The State/Territory assures EPSDT services will be provided to individuals under 21 years old who are covered under the State/Territory Plan under section 1902(a)(10)(A).

☐ Through Benchmark only.

X As an Additional benefit under section 1937 of the Act.

X The State/Territory assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

X The State/Territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

X The State/Territory assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries.

Wisconsin has instituted a transportation management system under the authority of section 1902(a)(7) of the Social Security Act.

X The State/Territory assures that family planning services and supplies are covered for individuals of child-bearing age.

6. Economy and Efficiency of Plans

X The State/Territory assures benchmark benefit coverage is provided in accordance with Federal upper payment limits procurement requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

7. Compliance with the Law

X The State/Territory will continue to comply with all other provisions of the Social Security Act in the administration of the State/Territory plan under this title.

8. Implementation Date

X The State/Territory will implement this State/Territory Plan amendment on *(date)*.

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Effective Date:

Coverage Offered through a Commercial HMO
Benchmark Plan
Attachment A

Service	Commercial Insurance
Ambulatory Surgery Centers	Coverage of certain surgical procedures and related lab services. Deductible & coinsurance.
Chiropractic Chiropractic (Continued)	PCP Copay if copay applies. Deductible and Coinsurance if no copay applies.
Dental	Accidental dental only; subject to deductible and coinsurance and limited. Limited to $3000 maximim per year, and $900 maximum per tooth.

Service	Commercial Insurance
Dental (Continued)	
Disposable Medical Supplies (DMS)	Ostomy supplies are limited to $2500 per year. Other DMS are deductible and coinsurance limitations apply, coverage is available if filled at the pharmacy under the prescription drug benefit.

Service	Commercial Insurance
DMS (Continued)	
Drugs Drugs (Continued)	Comprehensive prescription drug benefit; copays apply. Most common card is $10 Genric $35 Brand $60 Non-Preferrred Brand $100 Specialty injectible drugs OTC drugs are not covered. Tiering changes 2 times per year. Drugs are place on tiers based on chemical effectiveness versus cost.

Service	Commercial Insurance
Drugs (Continued)	
Durable Medical Equipment (DME) Durable Medical Equipment (DME) cont'd	Deductible and coinsurance; limited to $2500 per year; single purchase of a type of DME (including repair & replacement) every 3 years. Cochlear implants are included under DME as required by WI state law.
End-Stage Renal Disease (ESRD)	Deductible and coinsurance, preservice notification required.
Health Screenings for Children	Preventative physicals covered at 100%; no copay or deducitble applies. Sports physicals are not covered.

Service	Commercial Insurance
Hearing Services	Hearing screenings covered under preventative physical benefit. No coverage for hearing aids. Cochlear implants are covered under durable medical equipment.
Hearing Services (Continued)	

Service	Commercial Insurance
Home Care Services (Home Health, Private Duty Nursing [PDN], and Personal Care)	Deductible and coinsurance limited to 60 visits per year.
Hospice Hospice (Continued)	Deductible and coinsurance apply.
Inpatient Hospital	Deductible and Coinsurance apply.

Service	Commercial Insurance
Inpatient Hospital (Continued)	
Mental Health and Substance Abuse Treatment	Deductible and Coinsurance; copay applies for outpatient office calls and transitional treatment
Mental Health and Substance Abuse Treatment (Continued)	

Service	Commercial Insurance
Mental Health and Substance Abuse Treatment (Continued)	

Service	Commercial Insurance
Mental Health and Substance Abuse Treatment (Continued)	
Nursing Home Services	Skilled nursing facility/inpatient rehab facility services: 30 days per inpatient stay for skilled nursing services; 60 days per year for inpatient rehab services
Outpatient Hospital — Emergency Room	$250 copay applies on copay plans followed by 100% coverage; deductible & coinsurance applies on non-copay plans

Service	Commercial Insurance
Outpatient Hospital	Deductible & coinsurance
Outpatient Hospital (Continued)	

Service	Commercial Insurance
Physical Therapy (PT), Occupational Therapy, and Speech and Language Pathology (SLP) Physical Therapy (PT), Occupational Therapy, and Speech and Language Pathology (SLP) (Continued)	Copay applies on copay plans, deducitble and coinsurance applies on non-copay plans. Benefits are limited to 20 visits for PT, 20 visits for OT, 20 visits for speech, 20 visits for pulmonary rehabilitation, 36 visits for post-cochlear implant aural surgery, visits do not apply to manipulative treatment or autism.
Physician	Copay applies on copay plans followed by 100% including any laboratory services when completed at an in network facility. Deductible and coinsurance apply on non-copay plans.

Service	Commercial Insurance
Physician (Continued) Physician (Continued)	
Podiatry	Subject to a copay on copay plans or deductible and coinsurance on non-copay plans.

Service	Commercial Insurance
Podiatry (Continued)	
Prenatal/Maternity Care	Deductible and coinsurance.
Reproductive Health Service	Deductible and coinsurance. No coverage for fertility services.
Routine Vision	Subject to an office call copay on copay plans and deducitble and coinsurance on non-copay plans. Vision screenings are covered at 100% under the preventive benefit.

Service	Commercial Insurance
Routine Vision (Continued)	
Transportation — Ambulance, Specialized Medical Vehicle (SMV), Common Carrier Transportation — Ambulance, SMV, Common Carrier (Continued)	Deductible and coinsurance for air and ground.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

It should be noted that States can select one or more options in imposing cost sharing (including co-payments, co-insurance, and deductibles) and premiums.

A. For groups of individuals with family income above 100 percent but at or below 150 percent of the FPL:

1. Cost sharing

a. __/ No cost sharing is imposed.

b. X/ Cost sharing is imposed under section 1916A of the Act as follows [specify the amounts by group and services (see below)]:

Type of Charge

Group of Individuals	Item/Service	Deductible	Co-insurance	Co-payment	*Method of Determining Family Income (including monthly or quarterly period)
Benchmark Parents and caretaker relatives , with incomes above 100% and at or below 150% of the official Federal income poverty line 1902(a)(10)(A)(ii) Mandatory categorically needy poverty level infants of 100-150% of the federal poverty line, 1902(a)(10)(A)(i)(IV) Newborns who are deemed eligible under 1902(e)(4) and were born to women with family incomes of 100-150% of the federal poverty line, 1902(a)(10)(A)(i) Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance of 100-150% of the federal poverty line Mandatory categorically needy poverty level children age 1-5 of 100-150% of the federal poverty line, eligible under 1902(a)(10)(A)(i)(VI) Children 6-18 with incomes above 100 through 150% of the federal poverty line eligible under 1902(a)(10)(A)(ii)(XIV)	Refer to Attachments 4.18-F	None	Refer to Attachments 4.18-F	Refer to Attachments 4.18-F	

*Describe the methodology used to determine family income if it differs from your methodology for determining eligibility.

The methodology used to determine family income is the same as the methodology used to determine eligibility.

Attach a schedule of the cost sharing amounts for specific items and services and the various eligibility groups.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

b. Limitations:

- The total aggregate amount of cost sharing and premiums imposed under section 1916A for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a monthly and quarterly basis as specified by the State above.
- Cost sharing with respect to any item or service may not exceed 10 percent of the cost of such item or service.

c. No cost sharing will be imposed for any of the following services:

- Services furnished to individuals under 18 years of age that are required to be provided Medicaid under section 1902(a)(10)(A)(i), and including services furnished to individuals with respect to whom aid and assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age.
- Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age, regardless of family income.
- Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy.
- Services furnished to a terminally ill individual who is receiving hospice care, [as defined in section 1905(o) of the Act].
- Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.
- Emergency services as defined by the Secretary for the purposes of section 1916(a)(2)(D) of the Act.
- Family planning services and supplies described in section 1905(a)(4)(C) of the Act.
- Services furnished to women who are receiving Medicaid by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

d. Enforcement

1. _X_/ Providers are permitted to require, as a condition for the provision of care, items, or services, the payment of any cost sharing.
2. _X_/ (If above box selected) Providers permitted to reduce or waive cost sharing on a case-by-case basis.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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3. State payments to providers must be reduced by the amount of the beneficiary cost sharing obligations, regardless of whether the provider successfully collects the cost sharing.

4. States have the ability to increase total State plan rates to providers to maintain the same level of State payments when cost sharing is introduced.

2. Premiums

No premiums may be imposed for individuals with family income above 100 percent but below 150 percent of the FPL.

B. For groups of individuals with family income above 150 percent of the FPL:

1. Cost sharing amounts

a. __/ No cost sharing is imposed.

b. X/ Cost sharing is imposed under section 1916A of the Act as follows [specify amounts by groups and services (see below)]:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

Type of Charge

Group of Individuals	Item/Service	Deductible	Co-insurance	Co-payment	*Method of Determining Family Income (including monthly or quarterly period)
Benchmark Plan Parents and caretaker relatives , with incomes above 150% and at or below 200% of the official Federal income poverty line 1902(a)(10)(A)(ii) Newborns who are deemed eligible under 1902(e)(4) and were born to women with family incomes of 150 – 300% of the federal poverty line, whose eligibility was determined under 1902(a)(10)(A)(ii) or 1902(a)(10)(C) Infants with incomes from 150% through 300% of the federal poverty line, 1902(a)(10)(A)(ii)(IX) Mandatory categorically needy poverty level children age 1-5 with incomes of 150-185% of the federal poverty line, 1902(a)(10)(A)(i)(VI) Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance above 150% of the federal poverty line	Refer to Attachments 4.18-F	None	Refer to Attachments 4.18-F	Refer to Attachments 4.18-F	

*Describe the methodology used to determine family income if it differs from your methodology for determining eligibility.

The methodology used to determine family income is the same as the methodology used to determine eligibility.

Attach a copy of the schedule of the cost sharing amounts for specific items and the various eligibility groups.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Wisconsin

b. Limitations:

- The total aggregate amount of all cost sharing and premiums imposed under section 1916A for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a monthly or quarterly basis as specified by the State above.
- Cost sharing with respect to any item or service may not exceed 20 percent of the cost of such item or service.

c. No cost sharing shall be imposed for any of the following services:

- Services furnished to individuals under 18 years of age that are required to be provided Medicaid under section 1902(a)(10)(A)(i) of the Act, and including services furnished to individuals with respect to whom aid and assistance is made available under part B of title IV to children in foster care, and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age.
- Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age regardless of family income.
- Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy.
- Services furnished to a terminally ill individual who is receiving hospice care (as defined in section 1905(o) of the Act).
- Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.
- Emergency services as defined by the Secretary for the purposes of section 1916(a)(2)(D) of the Act.
- Family planning services and supplies described in section 1905(a)(4)(C) of the Act.
- Services furnished to women who are receiving Medicaid by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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c. No premiums shall be imposed for the following individuals:

- Individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i), and including individuals with respect to whom aid or assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age.
- Pregnant women.
- Any terminally ill individual receiving hospice care, as defined in section 1905(o).
- Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.
- Women who are receiving Medicaid by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

d. Enforcement

1. X / Prepayment required for the following groups of individuals who are applying for Medicaid: Infants with incomes from 200 - 300% FPL

2. X / Eligibility terminated after failure to pay for 60 days for the following groups of individuals who are receiving Medicaid: Infants with incomes from 200 - 300% FPL

3. __/ Payment will be waived on a case-by-case basis for undue hardship.

C. Period of determining aggregate 5 percent cap

Specify the period for which the 5 percent maximum would be applied.

_X_/ Quarterly

___/ Monthly

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D. Method for tracking cost sharing amounts

Describe the State process used for tracking cost sharing and informing beneficiaries and providers of their beneficiary's liability and informing providers when an individual has reached his/her maximum so further costs are no longer charged.

The Department will monitor cost sharing expenditures on a quarterly basis to identify families with income below 150% of the FPL for whom out of pocket premium and co-payment costs have reached the cap of 5% of their income.

As an interim process, we are notifying families in the Enrollment & Benefits booklet that the Department will monitor their cost sharing expenditures on a quarterly basis to identify any family with out of pocket premium and co-payment costs that exceeded 5% of their income and will issue a refund in the amount that co-payments exceeded their family limit.

Once our system enhancements are implemented, the CARES Notices of Decision will include a new section to inform the recipients of the maximum dollar amount that their families have to contribute as a share of the cost of the SCHIP/Medicaid benefits they are receiving. This maximum will be 5% of their countable income as calculated by CARES.

The Department will develop a systems solution within the Medicaid Management Information System (MMIS) to track the cost sharing expenses and alert providers when co-payments are to no longer be charged to families.

Also describe the State process for informing beneficiaries and providers of the allowable cost sharing amounts.

The State informs providers and members (beneficiaries) of allowable cost sharing amounts via Provider Updates and member Enrollment and Benefits booklet.

	BadgerCare Plus - Benchmark Plan		
Service/Item	**Copayment**	**Cost-Sharing**	**Deductible**
Ambulance Services	$50 co-payment per trip.		n/a
Chiropractic Services	$15 co-payment per visit.		n/a
Dental Services	$15 co-payment per visit.		n/a
		50% cost-sharing for dentures for members 21 years of age or older.	
Disposable Medical Supplies	$0.50 co-payment per priced unit.		n/a
Drugs	$4 co-payment for generic drugs $8 copayment for brand name drugs		n/a
Durable Medical Equipment	$5 co-payment per item. Co-payment is capped at $2,500 of paid amount in an enrollment year.		n/a
	Rental items are not subject to co-payment but count toward the $2,500 cap.		
Enhanced Pregnancy-Related Services (care coordination, health education, preventive mental health and substance abuse screening)	No co-payment.		n/a
Family Planning Services and Supplies	No co-payment.		n/a
Health Screenings (EPSDT) for Children under age 21 years.	No copayment.		n/a
Home Health Services	$15 co-payment per visit.		n/a
Hospice Services	No copayment.		n/a

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	BadgerCare Plus - Benchmark Plan	
Service/Item	**Copayment**	**Deductible**
Inpatient Hospital Services	$100 per stay for medical stays	n/a
	$50 co-payment per stay for mental health and/or substance abuse treatment	
Mental Health and Substance Abuse Treatment	No co-payment.	n/a
Nursing Home Services	No co-payment.	n/a
Outpatient Hospital Services	$15 co-payment per visit (multiple visits to the same provider in the same day will be treated as a single visit)	n/a
	$100 co-payment for emergency room visits (waived if admitted to hospital)	
Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST)	$15 co-payment per visit per date of service.	n/a
Physician Services (including laboratory and radiology services)	$15 co-payment per visit.	n/a
	No co-payment for preventive services and pregnancy-related services.	
	No co-payment for emergency services.	
	No copayment for clozapine management.	n/a
	No copayment for anesthesia.	
Podiatry Services	$15 co-payment per visit.	n/a

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	BadgerCare Plus - Benchmark Plan	
Service/Item	**Copayment**	**Deductible**
Vision Care Services	$15 co-payment per visit.	n/a
Providers are permitted to require, as a condition for the provision of care, items, or services, the payment of any cost sharing.		
Providers are permitted to reduce or waive cost sharing on a case-by-case basis.		

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 7.

6.1 The state elects to provide the following forms of coverage to children: (Check all that apply.) **(42 CFR 457.410(a))**

6.1.1 ☒ Benchmark coverage; **(Section 2103(a)(1) and 42 CFR 457.420) ***

6.1.1.1 ☐ FEHBP-equivalent coverage; **(Section 2103(b)(1))** (If checked, attach copy of the plan.)

6.1.1.2 ☐ State employee coverage; **(Section 2103(b)(2))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3 ☒ HMO with largest insured commercial enrollment **(Section 2103(b)(3))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2 ☒ Benchmark-equivalent coverage; **(Section 2103(a)(2) and 42 CFR 457.430)** Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. **See instructions.**

The State will solicit proposals from managed care organizations either to provide the HMO benefit package that has the largest insured commercial, non-Medicaid enrollment in the State, or to provide a benefit package that meets the requirements for benchmark-equivalent coverage under SSA § 1937(b)(2). In the event the State receives one or more acceptable proposals to provide a benefit package that meets the requirements for benchmark-equivalent coverage, the State will make all required assurances and showings relating to actuarial equivalence.

6.1.3 ☐ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4 ☒ Secretary-Approved Coverage. **(Section 2103(a)(4)) (42 CFR 457.450)**

6.1.4.1 ☐ Coverage the same as Medicaid State plan

6.1.4.2 ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project

6.1.4.3 ☒ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

6.1.4.4 ☒ Coverage that includes benchmark coverage plus additional coverage

6.1.4.5 ☐ Coverage that is the same as defined by existing comprehensive state-based coverage

6.1.4.6 ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7 ☐ Other (Describe)

6.2 The state elects to provide the following forms of coverage to children:
(Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations)
(Section 2110(a)) (42 CFR 457.490)

For the unborn child, the State covers pregnancy related services and services that if not treated could complicate the pregnancy.

The services checked below are for our separate SCHIP population of children from birth to 19 years up to and including 300% FPL. Details about the amount, duration and scope of the covered services are provided in Attachment 3.

6.2.1 ☒ Inpatient services **(Section 2110(a)(1))**

6.2.2 ☒ Outpatient services **(Section 2110(a)(2))**

6.2.3 ☒ Physician services **(Section 2110(a)(3))**

6.2.4 ☒ Surgical services **(Section 2110(a)(4))**
See Physician Services in Attachment 3

6.2.5 ☒ Clinic services (including health center services) and other ambulatory health care services **(Section 2110(a)(5))**
See Physician Services in Attachment 3

and in all cases as expeditiously as the enrollee's condition requires:

1) Within 14 calendar days of the receipt of the request, or

2) Within three business days if the physician indicates or the HMO determines that following the ordinary time frame could jeopardize the enrollee's health or ability to regain maximum function.

One extension of up to 14 calendar days may be allowed if the enrollee requests it or if the HMO justifies the need for more information.

Section 8. Cost Sharing and Payment **(Section 2103(e))**

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 9.

8.1 Is cost-sharing imposed on any of the children covered under the plan? **(42 CFR 457.505)**

8.1.1 ☒ YES

8.1.2 ☐ NO, **skip to question 8.8.**

8.2 Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate. **(Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b) & (c), 457.515(a)&(c))**

8.2.1 Premiums:

Premiums will be imposed upon children with monthly family income greater than 200% FPL. The rate is based upon family income and will not exceed 5% of monthly family income. Recipients will receive a notice telling them how much their premiums will be. Children ages 1 – 18, with
Incomes at or above 200 percent up to, but not including 230 percent of the FPL: $10;
Incomes at or above 230 percent up to, but not including 240 percent of the FPL: $15;
Incomes at or above 240 percent up to, but not including 250 percent of the FPL: $23;
Incomes at or above 250 percent up to, but not including 260 percent of the FPL: $34;
Incomes at or above 260 percent up to, but not including 270 percent of the FPL: $44;
Incomes at or above 270 percent up to, but not including 280 percent of the FPL: $55;
Incomes at or above 280 percent up to, but not including 290 percent of the FPL: $68;
Incomes at or above 290 percent up to, but not including 300 percent of the FPL: $82;
Incomes at 300 percent of the FPL: $97.53.

8.2.2 Deductibles:

8.2.3 Coinsurance or copayments:

Description of Children Affected	Premium	Co-payments
Children ages 1 - 5 with incomes >185 FPL up to and including 200% FPL	None	See Attachment 2, included at the end of Section 8
Children ages 6 - 18 with incomes > 150% FPL up to and including 200% of FPL	None	
Children ages 1 - 18 with incomes from 200 - 300% FPL	200 < 230% FPL - $10 230 < 240% FPL - $15 240 < 250% FPL - $23 250 < 260% FPL - $34 260 < 270% FPL - $44 270 < 280% FPL - $55 280 < 290% FPL - $68 290 - 299.99% FPL - $82 300% FPL – $97.53	See Attachment 2, included at the end of Section 8

No cost sharing will be applied to unborn children.

8.3 Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. **(Section 2103(e)((1)(B)) (42 CFR 457.505(b))**

Outreach and application forms will include this information. Sections 2.2.1, 5.1, and 9.9 provide detailed descriptions of our outreach efforts. In addition, the State informs providers and members (beneficiaries) of allowable cost sharing amounts via Provider Updates and member Enrollment and Benefits booklet.

8.4 The state assures that it has made the following findings with respect to the cost sharing in its plan: **(Section 2103(e))**

8.4.1 ☑ Cost-sharing does not favor children from higher income families over lower income families. **(Section 2103(e)(1)(B)) (42 CFR 457.530)**

8.4.2 ☑ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. **(Section 2103(e)(2)) (42 CFR 457.520)**

8.4.3 ☑ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. **(Section 2103(e)(1)(A)) (42 CFR 457.515(f))**

8.5 Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: **(Section 2103(e)(3)(B)) (42 CFR 457.560(b) and 457.505(e))**

The Department will monitor cost sharing expenditures on a quarterly basis to identify families with income below 150% of the FPL for whom out of pocket premium and co-payment costs have reached the cap of 5% of their income.

As an interim process, we are notifying families in the Enrollment & Benefits booklet that the Department will monitor their cost sharing expenditures on a quarterly basis to identify any family with out of pocket premium and co-payment costs that exceeded 5% of their income and will issue a refund in the amount that co-payments exceeded their family limit.

Once our system enhancements are implemented, the CARES Notices of Decision will include a new section to inform the recipients of the maximum dollar amount that their families have to contribute as a share of the cost of the SCHIP/Medicaid benefits they are receiving. This maximum will be 5% of their countable income as calculated by CARES.

The Department will develop a systems solution within the Medicaid Management Information System (MMIS) to track the cost sharing expenses and alert providers when copayments are to no longer be charged to families.

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. **(Section 2103(b)(3)(D)) (42 CFR 457.535)**

The state ensures that American Indian and Alaska Native children, eligible for the separate SCHIP benefit, are excluded from cost-sharing by assigning them an eligibility code that identifies them as such. This identifying information is retained in the Medicaid Management Information System (e.g., claims processing and eligibility file) which automatically exempts all cost-sharing.

Providers are notified of this requirement via written Updates and through the various eligibility verification methods available in the state. Families identify their children as Alaskan Natives or American Indian Tribal members through the application process.

This provision of the Separate SCHIP does not apply as Native Americans or Alaskan Natives as neither group could be considered as undocumented aliens.

Attachment 2
Co-payment Table
Wisconsin SCHIP children with up to and including 300% FPL

Service/Item	Co-payment
Ambulance Services	$50 per trip
Ambulatory Surgery Services	$15 per visit
Chiropractic Services	$15 per visit
Dental Services	$15 per visit
Disposable Medical Supplies	$0.50 per priced unit
Drugs	$4 for generic $8 for brand name
Durable Medical Equipment	$5 per item, except rentals
Family Planning Services and Supplies	No co-payment
Health Screenings (EPSDT) for Children under age 21 years	No co-payment
Hearing Services	$15 per procedure
Home Health Services	$15 per visit

Service/Item	Co-payment
Hospice Services	No co-payment
Inpatient Hospital Services	• $50 per stay for mental health and/or substance abuse treatment • $100 per stay for medical stays
Mental Health and Substance Abuse Outpatient Treatment	No co-payment
Nursing Home Services	No co-payment
Occupational Therapy	$15 per visit
Outpatient Hospital Services	• $15 per visit (multiple visits to the same provider in the same day will be treated as a single visit) • $100 for emergency room visits (*waived if admitted to hospital*)
Physical Therapy	$15 per visit
Physician/Clinic Services (including Nurse Practitioner, Nurse Midwife, Laboratory and Radiology services)	$15 per visit , except for clozapine management, preventive services, and diagnostic services, emergency services and anesthesia.
Podiatry Services	$15 per visit
Speech Therapy (ST)	$15 per visit

Service/Item	Co-payment
Vision Care Services	$15 per visit

Attachment 3
Wisconsin Description of the Amount, Duration and Scope of Services Covered
Section 6.2

The following chart shows the amount, duration and scope of covered benefits provided to members of the Benchmark Plans.

Service	Coverage Under the BadgerCare Plus Benchmark Plan
Ambulatory Surgery Centers	Coverage of certain surgical procedures and related lab services. $15.00 copayment per visit.
Chiropractic	Full coverage. $15.00 copayment per visit.

Service	Coverage Under the BadgerCare Plus Benchmark Plan
Dental Dental (continued)	Full coverage for members 20 years of age and younger. For members 21 years of age and older, dental coverage is limited to: • Diagnostic • Preventive • Simple Restorative • Surgical Procedures • Dentures Cost Sharing: • $15 copayment per visit for all members
Disposable Medical Supplies (DMS)	Coverage of diabetic supplies, ostomy supplies, and other DMS that are required with the use of durable medical equipment (DME). $0.50 copayment per prescription for diabetic supplies. No copayment for other DMS.

Service	Coverage Under the BadgerCare Plus Benchmark Plan
Drugs	Coverage of generic drugs, certain preferred brand name drugs on Wisconsin Medicaid's Preferred Drug List and some OTC drugs. Members are limited to 5 prescriptions per month for opioid drugs. Prior authorization will be available for select drug classes and brand medically necessary drugs. Members will be automatically enrolled in BadgerRx Gold. This is a separate program administered by Navitus Health Solutions. Copayments are as follows: • $4.00 for generic drugs. • $8.00 for brand name drugs.

Service	Coverage Under the BadgerCare Plus Benchmark Plan
Durable Medical Equipment (DME) DME (continued)	Full coverage up to $2,500.00 per enrollment year. $5.00 copayment per item. Rental items are not subject to copayment but count toward the $2,500.00 enrollment year limit. The following items do not count towards the $2,500.00 enrollment year limit: • Hearing aids, hearing aid batteries, and accessories. • Bone-anchored hearing aids. • Cochlear implants. Hearing aid repairs are subject to the $2,500.00 enrollment year limit.
End-Stage Renal Disease (ESRD)	Full coverage. No copayment.
Health Screenings for Children	Full coverage of HealthCheck screenings and other services for individuals under the age of 21.
Hearing Services	Full coverage for members 17 years of age and younger. $15.00 per visit, regardless of the number or type of procedures administered during one visit.

Service	Coverage Under the BadgerCare Plus Benchmark Plan
Home Care Services (Home Health, Private Duty Nursing [PDN], and Personal Care)	Full coverage of home health services. Coverage limited to 60 visits per enrollment year. Private duty nursing and personal care services are not covered. $15.00 copayment per visit.
Hospice	Full coverage, up to 360 days per lifetime. No copayment.
Inpatient Hospital	Full coverage. Copayments are as follows: • $100.00 per stay for medical stays. • $50.00 copayment per stay for mental health and/or substance abuse treatment.
Mental Health and Substance Abuse Treatment	Full Coverage (not including room and board.) up to 200% FPL. No copayment.
Nursing Home Services	Full coverage for stays at skilled nursing homes limited to 30 days per enrollment year. No copayment.

Service	Coverage Under the BadgerCare Plus Benchmark Plan
Outpatient Hospital — Emergency Room	Full coverage. $100.00 copayment per visit (waived if the member is admitted to a hospital).
Outpatient Hospital	Full coverage. $15.00 copayment per visit.
Physical Therapy (PT), Occupational Therapy, and Speech and Language Pathology (SLP)	Full coverage, limited to 20 visits per therapy discipline, per enrollment year. Also covers up to 36 visits per enrollment year for cardiac rehabilitation provided by a physical therapist. (The cardiac rehabilitation visits do not count towards the 20-visit limit for PT.) Also covers up to a maximum of 60 SLP therapy visits over 20-week period following a bone anchored hearing aid or cochlear implant surgeries for members 17 years of age and younger. These SLP services do not count towards the 20-visit limit for SLP. $15.00 copayment per visit, per provider. There are no monthly or annual copayment limits.

Service	Coverage Under the BadgerCare Plus Benchmark Plan
Physician	Full coverage, including laboratory and radiology. $15.00 copayment per visit. No copayment for emergency services, anesthesia, preventive services or clozapine management.
Podiatry	Full coverage. $15.00 copayment per visit.
Prenatal/Maternity Care	Full coverage, including PNCC, and preventive mental health and substance abuse screening and counseling for women at risk of mental health or substance abuse problems. No copayment.
Reproductive Health Service	Full coverage, excluding infertility treatments, surrogate parenting, and the reversal of voluntary sterilization. No copayment for family planning services.
Routine Vision	One eye exam with refraction and a single pair of eye glasses per enrollment year. $15.00 copayment per visit.

Service	Coverage Under the BadgerCare Plus Benchmark Plan
Transportation — Ambulance, Specialized Medical Vehicle (SMV), Common Carrier	Full coverage of emergency and non-emergency transportation to and from a certified provider for a covered service. Copayments are as follows: • $50.00 copayment per trip for emergency transportation by ambulance. • $1.00 copayment per trip for transportation by SMV. • No copayment for transportation by common carrier.